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No. _____

IN THE

Supreme Court of the United States

OCTOBER TERM, 1980

STATE OF ARIZONA,
Petitioner,

vs.

MARICOPA COUNTY MEDICAL SOCIETY,
MARICOPA FOUNDATION FOR MEDICAL CARE, and
PIMA FOUNDATION FOR MEDICAL CARE,
Respondents.

PETITION FOR A WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE NINTH CIRCUIT

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QUESTION PRESENTED

Is an agreement among competing physicians establishing fee schedules for their individual services a *per se* violation of section 1 of the Sherman Act?

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Pima Foundation For Medical Care,
Respondents.

PETITION FOR A WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE NINTH CIRCUIT

The State of Arizona respectfully prays that a writ of certiorari issue to review the decision of the United States Court of Appeals for the Ninth Circuit entered on March 20, 1980, as modified April 28, 1980.

OPINIONS BELOW

The memorandum and order of the District Court entered June 5, 1979 (Appendix D), the order dated August 6, 1979 denying plaintiff's motion for reconsideration of the June 5 order and denying plaintiff's motion for summary judgment (Appendix E), the amendment to the June 5 order dated August 8, 1979 certifying that decision for interlocutory appeal (Appendix F), the preliminary order of the Court of Appeals filed November 19, 1979 (Appendix C), the opinion of Judge Sneed, the concurring opinion of Judge Kennedy and the dissenting opinion of Judge Larson[1] filed March 20, 1980 (Appendix A), the order of April 28,

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[1] Honorable Earl R. Larson, Senior United States District Judge for the District of Minnesota, sitting by designation.

1980, modifying the opinion of March 20, 1980 (Appendix B), and the Court of Appeals' orders of May 30, 1980 (Appendix G) and June 18, 1980 (Appendix H) concerning rehearing, have not been reported.

JURISDICTION

The opinion of the United States Court of Appeals for the Ninth Circuit was filed on March 20, 1980, and modified on April 28, 1980. The State of Arizona's petition for rehearing and rehearing en banc was denied on June 18, 1980.[2] The jurisdiction of this Court is invoked under 28 U.S.C. § 1254(1).

STATUTORY PROVISION INVOLVED

Section 1 of the Sherman Act, 15 U.S.C. § 1, provides in pertinent part:

> Every contract, combination in the form of trust or otherwise, or conspiracy, in restraint of trade or commerce among the several States or with foreign nations is declared to be illegal.

STATEMENT OF THE CASE

The Parties

The State of Arizona, brought this action on its own behalf and as *parens patriae* on behalf of its resident natural citizens seeking declaratory and injunctive relief against the establishment and use of uniform and agreed-upon fee

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[2] While the petition for rehearing and rehearing en banc was pending, defendants filed a motion to strike that petition on the ground that it was untimely. In an abundance of caution, Arizona applied for an extension of time within which to file its petition for a writ of certiorari and Mr. Justice Rehnquist granted that motion on June 10, 1980. However, the Ninth Circuit denied the motion to strike by ordering the petition filed, thereby finding it timely. Appendix G. See Rule 13(g), Rules of the United States Court of Appeals for the Ninth Circuit. This ruling rendered moot Mr. Justice Rehnquist's order extending the time within which to file the petition.

schedules by medical doctors in violation of section 1 of the Sherman Act, 15 U.S.C § 1. The District Court's jurisdiction was invoked under 28 U.S.C. §§ 1331 and 1337 and section 16 of the Clayton Act, 15 U.S.C. § 26.

Named as defendants were the Maricopa and Pima County Medical Societies which are associations of doctors in Arizona's two most populous counties.[3] These two medical societies had created the Maricopa and Pima Foundations for Medical Care which were also named as defendants.[4] The membership of the foundations includes more than 1,000 doctors in Maricopa County and more than 400 doctors in Pima County which are substantial proportions of the practicing physicians in those two areas.[5] The foundations' by-laws grant their members the power "to vote on the adoption of ... uniform fee schedules ... by mail ballot."[6]

Respondents Have Established and Maintained Uniform Fee Schedules for Doctors' Services

The respondents' fee schedules have two components, the "relative value" and the "conversion factor." The "relative value" is a numerical weight assigned for each type of service or procedure performed by a physician. Thus, a routine, follow-up office visit might have a relative value of 1.0, while a home visit might have a relative value of 7.0. The "conversion factor" is the dollar amount used to determine fees for a particular medical specialty. Thus, the conversion factor for surgery might be $10.00, while that for anesthesiology might be $13.00. The actual price charged for a particular procedure is determined by multiplying the

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[3] CR 106, No. 1. The Pima County Medical Society was named as a defendant but it agreed to a consent judgment after it severed its relationship with the Pima Foundation and is therefore no longer a party to this lawsuit. References are to the Clerk's Record designated in the Ninth Circuit Court of Appeals.

[4] CR 106, Nos. 1, 2, 3, 5, 6, 9, 10, 13, 16, 17, 18, 19, 21, 36.

[5] CR 106, Nos. 4, 31, 32, 35; Exhibit A to Affidavit of Alice McLain, Exhibit D-1 to CR 106.

[6] CR 106, Nos. 12, 13, 20, 21, 27, 28, 29.

relative value for that procedure by the applicable conversion factor.[7]

For more than a decade, the foundations have been the vehicle by which their members agreed upon "relative values," "conversion factors," and — in turn — agreed-upon fee schedules covering the entire spectrum of the medical marketplace.[8] To accomplish this end, the foundations polled their members and other medical associations regarding "any changes [they felt] would be appropriate."[9] The purpose was to obtain a "consensus" before distributing recommended increases in the fee schedules for a vote of the membership.[10] There were widespread discussions and agreements on acceptable fees and fee schedules.[11] Once adopted by formal vote, the fee schedules were sent both to foundation members and to other physicians in Arizona.[12] Some 85 to 95 percent of the foundations' members charge at or above the prices established by the foundations' "uniform fee schedules."[13]

The foundations also negotiated on behalf of their members on the prices for medical services to be paid by health insurers and other third parties. If an insurance company or other party agreed to pay the amounts set forth in the foundations' fee schedules, the foundations would formally endorse the health plans offered by those insurers or other third parties[14] and the foundations' members agreed to

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[7] CR 106, Nos. 49, 52-54.

[8] CR 106, Nos. 37-40, 48-50, 52-55, 57, 58.

[9] *E.g.*, Exhibits MF-27 to MF-46 to CR 7(b). See CR 106, Nos. 42, 61, 62, 64; See Exhibits MF-20 to MF-22 to CR 7(b).

[10] *E.g.*, Exhibits MF-2, MF-3 to CR 7(b); CR 106, No. 63.

[11] CR 106, Nos. 60-69.

[12] CR 106, Nos. 65-69.

[13] Exhibit B to CR 66, No. 72; CR 71 at 88.

[14] CR 106, Nos. 43-46, 48.

accept as full payment the amounts determined by the foundations' fee schedules.[15]

Although the defendants argued to the lower courts that the foundation fee schedules only established "maximum" fees, their fee schedules — by whatever name — have had an inflationary effect on prices in the medical market.[16] The foundations' fee schedules have been set at levels higher than both the average and median fees of Arizona doctors.[17] And, once the fee schedules were established, foundation members revised their prices so that some 85 to 95 percent charged prices at or above the prices established by those fee schedules. Indeed, defendants readily admitted that member doctors expected and demanded concerted price increases as a requisite for continued membership in the foundations.[18]

Proceedings Below

The District Court

The State of Arizona brought this action for declaratory and injunctive relief on its own behalf and as *parens patriae* on behalf of its resident citizens. Following completion of relevant discovery, the State of Arizona moved for partial summary judgment on liability on the ground that defen-

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[15] Appendix D at 5; CR 106, Nos. 14, 22, 30, 34, 42, 48, 70. Neither the foundations nor their members have underwritten any of the acturial risk associated with that insurance coverage; that risk was borne entirely by the insurers which financed and marketed the plans. Appendix D at 2-4; CR 106, No. 44.

[16] Indeed, the foundations sought a bond in the district court in the amount of $1.8 million per month to cover the estimated price increase they had been temporarily enjoined from effecting. CR 103 at 10. See the dissenting opinion of Judge Larson, Appendix A at 28-31.

[17] CR 106, No. 71.

[18] In both the district court and the court of appeals, respondents claimed that doctors were threatening to leave the foundations if they could not increase their agreed-upon fees, an open admission that fees for individual services were controlled by the collective membership and could not be adjusted individually by doctor or insurer. See the dissenting opinion of Judge Larson, Appendix A at 29-30; CR 103 at 5; CR 104; Appellees' Brief in the Court of Appeals at 24.

dants' price-fixing activities were a *per se* violation of section 1 of the Sherman Act, 15 U.S.C. § 1. The District Court denied this motion on June 5, 1979.[19] It reasoned that *Continental T.V., Inc. v. GTE Sylvania, Inc.*, 433 U.S. 36 (1977), established a trend away from the *per se* rule and that the *per se* rule would no longer be applicable to price-fixing agreements. Alternatively, it interpreted *Goldfarb v. Virginia State Bar*, 421 U.S. 773 (1975), and *National Society of Professional Engineers v. United States*, 435 U.S. 679 (1978), to mean that the *per se* rule could never be applied against professionals, even in a horizontal price-fixing case such as this. Subsequent motions for reconsideration of the June 5, 1979, order and for partial summary judgment on liability based upon the rule of reason were also denied. On August 8, 1979, the district court certified for interlocutory appeal pursuant to 28 U.S.C. § 1292(b) its June 5 "determination that the Rule of Reason approach should be used in analyzing the challenged conduct ... to determine whether a violation of Section 1 of the Sherman Act has occurred ...." (Appendix F.)

The Court of Appeals

A divided panel of the Court of Appeals affirmed with Judges Sneed and Kennedy each writing individual opinions and Senior District Judge Larson filing a dissent.

Relying on *Broadcast Music, Inc. v. Columbia Broadcasting Co.*, 441 U.S. 1 (1979), and distinguishing *United States v. Socony-Vacuum Oil Co.*, 310 U.S. 150 (1940), Judge Sneed reasoned that it was impossible to determine whether the doctors' fee schedules were *per se* unlawful without first determining whether the agreed-upon prices were unreasonably high, unreasonably low, or were higher

[19] Appendix D. The Memorandum and Order of June 5, 1979, also denied defendants' motion to dismiss the complaint and granted plaintiff's motion for partial summary judgment on the issue of subject matter jurisdiction. Only that portion of the June 5, 1979, order which addressed the issue of liability was appealed.

than other fee schedules.[20] Even if the doctors' fee schedules were viewed simply as establishing maximum prices, Judge Sneed was unwilling to hold them *per se* unlawful. He declined to follow *Albrecht v. Herald Co.*, 390 U.S. 145 (1968), and *Kiefer-Stewart Co. v. Joseph E. Seagram & Sons*, 340 U.S. 211 (1951), saying, "This circuit has not extended those rulings to horizontal agreements that establish maximum prices." (Appendix A at 7.)

Judge Sneed also followed the district court in saying that the *per se* rule could never be applied to the anticompetitive activities of doctors. Judge Kennedy concurred, stating that a trial was necessary before the *per se* rule could be applied. (Appendix A at 12-13.)

Senior District Judge Larson dissented. He rejected the reasoning of the District Court and Judge Sneed "that per se rules were being supplanted by greater use of the rule of reason." He concluded that this was the sort of "naked price restraint" which had previously been adjudged illegal *per se* and that there was no peculiarity of the health care industry that justified the application of a less strict legal standard to defendants' conduct. And, finally, Judge Larson rejected the defense recognized by Judge Sneed that the

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[20] Judge Sneed reasoned, "[w]e do not know how health insurers such as Blue Cross fix their fee schedules in the relevant geographic area or whether the fees they offer exceed the appellees' maximum fees .... This makes it impossible to evaluate the pro- and anticompetitive aspects of a given feature of the total structure, although these aspects must be weighted together in determining whether a per se rule, or even the Rule of Reason, should brand the questioned feature illegal." Appendix A at 8-9.

Judge Sneed went on to speculate that the doctors' agreed-upon fee schedules might be unreasonably low so as to discourage entry of new competitors or unreasonably high so as to exact a monopoly profit and that until the reasonableness of the foundations' fee schedules was determined it would be impossible to determine whether they were *per se* unlawful. Appendix A at 9-11.

reasonableness of the price is a defense to a price-fixing charge.[21]

REASONS FOR GRANTING THE WRIT

I. In Ruling that the Reasonableness of the Agreed-Upon Price Is a Defense to a Price-Fixing Charge, the Ninth Circuit Has Adopted an Unworkable Standard that Has Been Expressly Repudiated by this Court and the Other Courts of Appeals.

Certain agreements and practices by competitors are so plainly anticompetitive and pernicious that they are considered *per se* unlawful.[22] Under the *per se* rule, once such conduct is proved no further inquiry into its purposes or economic consequences is necessary to show a violation of the Sherman Act.[23] Unquestionably, agreements regarding price top the list of conduct falling under the *per se* rule; they have been considered *per se* unlawful since the inception of the rule. *Catalano, Inc. v. Target Sales, Inc.*, 100 S.Ct 1925, 1927 (1980); *National Society of Professional Engineers v. United States*, 435 U.S. at 692; *Goldfarb v. Virginia State Bar*, 421 U.S. at 785; *United States v. National Ass'n of Real Estate Bds.*, 339 U.S. 485, 489 (1950); *United States v. Addyston Pipe & Steel Co.*, 85 F. 271, 291 (6th Cir. 1898), *aff'd*, 175 U.S. 211 (1899).

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[21] Appendix A at 19-32. Judge Larson said, "I do not agree with the majority's belief that the relevant inquiry is whether fees are higher or lower as a result of the defendants' conduct. I am confident that the fee schedule does have the effect of raising prices, and that in its absence consumers would ultimately obtain less expensive medical care. The majority's emphasis on the level of fees, however, is a version of the 'reasonableness of prices' justification for price-fixing. This defense has been repeatedly rejected." (Appendix A at 30.)

[22] *E.g. National Society of Professional Engineers v. United States*, 435 U.S. at 692; *Northern Pac. R. Co. v. United States*, 356 U.S. 1, 5 (1958).

[23] *Catalano, Inc. v. Target Sales, Inc.*, 100 S.Ct. 1925, 1927 (1980); *Northern Pacific R. Co. v. United States*, 356 U.S. at 5.

Nonetheless, the Ninth Circuit rejected application of the *per se* rule in this case. In support of its result the court relied upon an analysis of the economic effect of the pricing conduct, stating, "The relevant inquiry becomes whether fees paid to doctors [absent agreed-upon fee schedules] would be less than those payable under the FMC maximum fee agreement." (Appendix A at 6.) By adopting a construction of the Sherman Act that the relevant issue in a price-fixing case is whether prices might have been lower in the absence of the conspiracy, the Ninth Circuit broke with the law as set forth both by this Court and the other courts of appeals.

A. The Ninth Circuit's Opinion Conflicts with the Decisions of this Court.

In the recent reversal of another of Judge Sneed's "rule of reason" analyses in *Catalano, Inc. v. Target Sales, Inc.*, this Court emphasized that "[i]t has long been settled that an agreement to fix prices is unlawful *per se*. It is no excuse that the prices fixed are themselves reasonable."[24] Indeed, this Court's consistent holdings have unequivocally foreclosed the inquiry into the reasonableness of agreed-upon prices which Judge Sneed's opinion mandates.[25] What offends the Sherman Act is the power to control prices by private agreement, not the relative reasonableness or unreasonableness of a particular price under variable economic conditions.[26]

The Ninth Circuit not only adopted the "reasonable price" defense that had been repeatedly rejected by this Court, it placed upon the plaintiff the burden of proving that prices would have been lower if 80 percent of the doctors in the community had not adopted and circulated

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[24] 100 S. Ct. at 1927, *citing United States v. Trenton Potteries Co.*, 273 U.S. 392, 397-398 (1927); *United States v. Trans-Missouri Freight Ass'n*, 166 U.S. 290, 340-341 (1897).

[25] *E.g., National Society of Professional Engineers v. United States*, 435 U.S. at 689.

[26] *United States v. Socony-Vacuum Oil Co.*, 310 U.S. at 212-24; *United States v. Trenton Potteries Co.*, 273 U.S. at 397.

uniform fee schedules for more than a decade. This burden of proof directly contradicts the established standard of liability. "In a civil action under the Sherman Act, liability may be established by proof of either an unlawful purpose or an anticompetitive effect."[27] The Ninth Circuit has ignored that rule and established a contradictory standard which confuses an effect on price with the requisite effect on competition and avoids the true issue, whether the agreed-upon fee schedules restrain competition.

B. The Ninth Circuit's Opinion Conflicts with the Decisions of Other Courts of Appeals.

The circuit courts of appeals, following the lead of this Court in *Socony-Vacuum* and *Trenton Potteries*, have consistently rejected any attempts to justify price-fixing combinations on the basis of the reasonableness of the

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[27] *McLain v. Real Estate Bd. of New Orleans, Inc.*, 444 U.S. 232, 243 (1980); *United States v. United States Gypsum Co.*, 438 U.S. 422, 436 n.13 (1978). In *McLain* this Court made it clear that a plaintiff need not quantify the adverse impact of a defendant's conduct to secure injunctive relief. 444 U.S. at 243. The State of Arizona has sought only injunctive and declaratory relief in this case.

prices.[28] In ruling that the reasonableness of price may be a defense to a charge of price fixing, the Ninth Circuit has chosen to reverse single-handedly precedent that has been followed by the circuits since this Court's 1899 ruling in *Addyston Steel*.[29] For the Ninth Circuit now to say that the level of the price set by the physicians determines lia-

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[28] *See, e.g.*, First Circuit: *Kartell v. Blue Shield of Mass., Inc.*, 592 F.2d 1191, 1193 n.2 (1st Cir. 1979); *Ford Motor Co. v. Webster's Auto Sales, Inc.*, 361 F.2d 874 (1st Cir. 1966); Second Circuit: *Ring v. Spina*, 148 F.2d 647 (2d Cir. 1945); *Connecticut Importing Co. v. Continental Distilling Corp.*, 129 F.2d 651 (2d Cir.), *cert. denied*, 317 U.S. 664 (1942). Third Circuit: *Wholesale Auto Supply Co. v. Hickok Manufacturing Co.*, 221 F. Supp. 935 (D.N.J. 1963); *United States v. Vehicular Parking, Ltd.*, 54 F. Supp. 828 (D. Del. 1944). Fourth Circuit: *Virginia Excelsior Mills, Inc. v. Federal Trade Commission*, 256 F.2d 538 (4th Cir. 1958); *Pennsylvania Water & Power Co. v. Consolidated Gas, Electric, Light & Power Co.*, 184 F.2d 552 (4th Cir.), *cert. denied*, 340 U.S. 906 (1950). Fifth Circuit: *State of Alabama v. Blue Bird Body Co.*, 573 F.2d 309 (5th Cir. 1978); *Greene v. General Foods Corp.*, 517 F.2d 635 (5th Cir. 1975), *cert. denied*, 424 U.S. 942 (1976); *Denison Mattress Factory v. The Spring-Air Co.*, 308 F.2d 403 (5th Cir. 1962). Sixth Circuit: *Lewis v. Pennington*, 400 F.2d 806 (6th Cir.) *cert. denied*, 393 U.S. 983 (1968); *Barber-Coleman Co. v. Nat'l Tool Co.*, 136 F.2d 339 (6th Cir. 1943). Seventh Circuit: *Sun Oil Co. v. Federal Trade Commission*, 350 F.2d 624 (7th Cir. 1965), *cert. denied*, 382 U.S. 982 (1966); *Henry G. Meigs, Inc. v. Empire Petroleum Co.*, 273 F.2d 424 (7th Cir. 1960). Eighth Circuit: *Sun Oil Co. v. Vickers Refining Co.*, 414 F.2d 383 (8th Cir. 1969). Tenth Circuit: *United States v. Utah Pharmaceutical Ass'n*, 201 F. Supp. 29 (D. Utah), *aff'd*, 371 U.S. 24 (1962). District of Columbia Circuit: *United States v. Nat'l Soc'y of Professional Engineers*, 555 F.2d 978 (D.C. Cir. 1977), *aff'd*, 435 U.S. 679 (1978).

[29] Indeed, the language of this Court's 1927 opinion in the *Trenton Potteries* case rejecting the reasonableness of prices as a defense figures prominently in the circuit court opinions. *E.g., State of Alabama v. Blue Bird Body Co.*, 573 F.2d 309, 317 (5th Cir. 1978) ("Hence it is no defense that the price fixed was actually a 'reasonable price.' "); *Greene v. General Foods Corp.*, 517 F.2d 635, 648 (5th Cir. 1975) ("The reasonable price fixed today may through economic and business changes become the unreasonable price tomorrow."); *Lewis v. Pennington*, 400 F.2d 806, 812 (6th Cir.), *cert. denied*, 393 U.S. 983 (1968) ("a combination to restrain trade by fixing prices, regardless of the reasonableness of such price, is illegal per se.").

bility in a price-fixing case is to create a new standard which directly conflicts with established law.

C. The Ninth Circuit's Opinion Promulgates an Impracticable and Unworkable Standard.

The inquiry into the relative reasonableness of agreed-upon prices which the Ninth Circuit has prescribed will place an intolerable burden on the district courts and represent an unprecedented and unwise obstacle to antitrust enforcement. As this Court has long held, tortuous case-by-case analysis of the economic peculiarities of various industries is unnecessary to determine the anticompetitive character of horizontal price agreements. Those agreements strike at the very heart of the Sherman Act and are appropriately subject to *per se* analysis without "the necessity of minute inquiry whether a particular price is reasonable or unreasonable as fixed and without placing on the government ... the burden of ascertaining from day to day whether it has become unreasonable through the mere variation of economic conditions." *United States v. Trenton Potteries Co.*, 273 U.S. at 397-398.

Until this decision, it was well-understood that agreements among competitors regarding price were forbidden by the Sherman Act. By adopting a construction of the Act which makes "the difference between legal and illegal conduct in the field of business relations depend upon so uncertain a test as whether prices are reasonable—a determination which can be satisfactorily made only after a complete survey of our economic organization and a choice between rival philosophies,"[30] the Ninth Circuit has undermined the most basic tenet of the antitrust laws.

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[30] *United States v. Trenton Potteries Co.*, 273 U.S. at 398.

II. By Holding that Horizontal Maximum Price-Fixing Is Not Per Se Unlawful, the Ninth Circuit Creates a Conflict with this Court and Other Courts of Appeals.

This court has made it clear that maximum price-fixing is unlawful *per se*. "For such agreements, no less than those to fix minimum prices, cripple the freedom of traders and thereby restrain their ability to sell in accordance with their own judgment." *Kiefer-Stewart Co. v. Joseph E. Seagram & Sons, Inc.*, 340 U.S. at 213. *Accord, Albrecht v. Herald Co.*, 390 U.S. at 153; *California Retail Liquor Dealers Ass'n v. Midcal Aluminum, Inc.*, 445 U.S. 97 (1980).

In no other circuit can competitors avoid the *per se* rule against price-fixing by denominating their agreed price level a "maximum." To the contrary, other circuits have expressly stated that horizontal maximum price-fixing is unlawful *per se*.[31]

This Court and the lower courts have long recognized that "an identical or parallel system of maximum prices between [competitors] is likely to become a system of minimum prices."[32] When maximum prices are set by a horizontal rather than a vertical agreement the anticompetitive consequences are even greater, and the tendency for the maximum price to function as a minimum price stronger, because the interests of the cartel are unchecked by the

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[31] First Circuit: *Kartell v. Blue Shield of Mass., Inc.*, 592 F.2d 1191, 1193 n.2 (1st Cir. 1979); *Quinn v. Mobil Oil Co.*, 375 F.2d 273, 274, 276-278 (1st Cir.)., *cert. dismissed*, 389 U.S. 801 (1967). Second Circuit: *Janel Sales Corp. v. Lanvin Parfums, Inc.*, 396 F.2d 398 (2d Cir.) *cert. denied*, 393 U.S. 938 (1968); *Vandervelde v. Put & Call Brokers & Dealers Assoc.*, 344 F.Supp. 113, 134 (S.D.N.Y. 1972). Fourth Circuit: *Virginia Excelsior Mills, Inc. v. Federal Trade Commission*, 256 F.2d 538 (4th Cir. 1958). Sixth Circuit: *Crane Distributing Co. v. Glenmore Distilleries*, 267 F.2d 343, 345 (6th Cir. 1959).

[32] *Quinn v. Mobil Oil Co.*, 375 F.2d 273, 277-278 (1st Cir. 1967) (Coffin J., concurring). *Accord, Albrecht v. Herald Co.*, 390 U.S. at 153 ("[I]f the actual price charged under a maximum price scheme is nearly always the fixed maximum price . . . that scheme tends to acquire all the attributes of an arangement fixing minimum prices.")

countervailing interests of any third party.[33] By ruling that the monopoly power of a cartel renders the *per se* rule against price-fixing inapplicable, Judge Sneed has created an exception which strikes at the very heart of the Sherman Act. The conflict created by his decision should be resolved.

III. By Creating a Special Standard of Liability for Doctors, the Ninth Circuit Departs Radically from the Holdings of this Court and Other Courts of Appeals

A. The Judicial Exemption for Doctors Created by the Ninth Circuit Is a Radical Departure from the Holdings of this Court.

As early as 1950, this Court held that fee schedules for professional services were unlawful *per se*. *United States v. National Association of Real Estate Boards*, 339 U.S. 485 (1950). In *Goldfarb v Virginia State Bar*, 421 U.S. 773 (1975), this Court ruled that members of a learned profession are not exempt from the Sherman Act. *Goldfarb* held fee schedules for legal services to be unlawful.[34] *National Society of Professional Engineers v. United States* held a professional society's rule against competitive bidding to be "illegal on its face," establishing that "no elaborate industry analysis is required to demonstrate the anticompetitive character of such an agreement." 435 U.S. at 692. The Ninth Circuit's opinion flies in the face of those holdings.

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[33] For this reason, informed commentators have urged that fee schedules promulgated by medical societies and their foundations for medical care "should be recognized as part of a profit-maximizing strategy of a coalition of monopolists [,]" and held per se unlawful. Havighurst, *Professional Restraints on Innovation in Health Care Financing*, 1978 Duke L.J. 303, 377-378; Kallstrom, *Health Care Cost Control by Third Party Payors: Fee Schedules and the Sherman Act*, 1978 Duke L.J. 645, 678-680. *See also* Havighurst and Kissam, *The Antitrust Implications of Relative Value Studies in Medicine*, J. Health Politics, Policy and Law, 48, 68 (Winter 1979).

[34] 421 U.S. at 781-783, 786-788. *See also United States v. Utah Pharmaceutical Ass'n*, 371 U.S. 24 (1962), *affirming per curiam* 201 F. Supp. 29 (D. Utah 1962) (pharmaceutical fee schedules held *per se* unlawful).

That opinion rests upon the premise that a combination of competitors having monopoly power may engage in horizontal price agreements without violating section 1 of the Sherman Act. Focusing upon the structure of the health care industry rather than the nature of the challenged agreement, the majority held that in "an industry widely deviant from a reasonably competitive model," the price mechanism may be controlled by a cartel. (Appendix A at 6.)

This premise is a radical departure from established Sherman Act analysis, which focuses upon the nature of the challenged agreement rather than the peculiarities of particular industries. *E.g., National Society of Professional Engineers v. United States*, 435 U.S. at 688. In this case, the challenged agreement is a compact among competitors on the prices they will accept for individual services. By its very character, it suppresses an essential form of competition. This Court has consistently held that such agreements are unlawful *per se*. *Catalano, Inc. v. Target Sales, Inc.*, 100 S.Ct. at 1927-28; *United States v. Socony-Vacuum Oil Co.*, 310 U.S. at 221.[35]

By deciding that competition does not and cannot work in the medical care industry and cartel pricing by doctors is therefore acceptable, the Ninth Circuit created an unprecedented exemption which, if allowed to stand, would be tantamount to a repeal of the statute. The Sherman Act has foreclosed argument that because of the special characteristics of a particular industry monopolistic arrangements will better promote trade and commerce than competition. *National Society of Professional Engineers v. United*

[35] The Court of Appeals' opinion unfortunately misconstrued this Court's holding in *Broadcast Music, Inc. v. Columbia Broadcasting Co.*, 441 U.S. 1 (1979), as exempting a traditional "form of minimum price fixing" from the *per se* rule. (Appendix A at 9.) But that decision established only that the blanket copyright licenses at issue did not constitute price-fixing. Indeed, this Court stated clearly in *BMI* that "agreements among competitors to fix prices on their individual goods or services are .... within the *per se* category." 441 U.S. at 8.

States, 435 U.S. at 689; *United States v. Joint Traffic Ass'n*, 171 U.S. 505, 573-77 (1898). Because the policy decision that competition is in the public interest has been made by Congress, the judiciary cannot confer monopoly privileges on a particular trade or industry.[36]

But if the peculiarities of the medical marketplace were relevant, they would only underscore the inappropriateness of having organized medicine control the price-setting function. As Judge Larson noted in dissent (Appendix A at 24-25), much of the distortion in the medical marketplace can be traced to the anticompetitive practices of traditional medical associations, practices which this Court has already held to be fully subject to antitrust enforcement.[37] The flowering of a competitive marketplace for health care in Minneapolis-St. Paul has demonstrated the benefits of price competition among doctors.[38] Recent experience has also shown that competing insurers can take meaningful

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[36] *National Society of Professional Engineers v. United States*, 435 U.S. at 695. Judge Sneed stresses that the supply and demand functions of the medical marketplace have been distorted by high barriers to entry and government subsidies of the costs of medical care. But those characteristics are no more prevalent in the health care industry than in the petroleum industry, the railroad industry, and a host of other industries which this Court, as Congress intended, has held fully subject to Sherman Act enforcement. *E.g., Northern Pacific R. Co. v. United States*, 356 U.S. 1 (1968); *United States v. Socony-Vacuum Oil Co.*, 310 U.S. 150 (1940).

[37] *American Medical Ass'n v. United States*, 317 U.S. 519 (1943). In *American Medical Ass'n*, No. 9064 (FTC Nov. 13, 1978) (Initial decision), at 137-140, 160-166, 178-179, 259, 260, Exhibit A to CR 73, anticompetitive practices of the Maricopa and Pima County Medical Societies were included in the findings of fact. See generally Goldberg and Greenberg, *The Effect of Physician-Controlled Health Insurance*, J. of Health Politics, Policy and Law 2, 48 (1977); Havighurst, *Professional Restraints on Innovation in Health Care Financing*, 1978 Duke L. J. 303.

[38] See Faltermayer, *Where Doctors Scramble for Patients' Dollars, Fortune Magazine* 114 (November 6, 1978).

steps to contain health care costs in an open market protected by the antitrust laws.[39]

B. The Circuits Are Now in Conflict Regarding a Doctors' Exemption from the Sherman Act.

The Courts of Appeals for the Fifth Circuit[40] and the District of Columbia Circuit[41] have applied the *per se* rule to price restraints by professional groups.[42] In *Ballard v. Blue Shield*, 543 F.2d 1075, 1079 (4th Cir. 1976), *cert. denied*, 430 U.S. 922 (1977), the Fourth Circuit applied the *per se* rule to a boycott case involving a refusal of insurance coverage for chiropractic services. In a more recent boycott case involving a refusal of insurance coverage for psychological services, however, the Fourth Circuit followed the Ninth Circuit in declining to apply a *per se* rule "because of the special considerations involved in the delivery of health services." *Virginia Academy of Clinical Psychologists v. Blue Shield*, 1980-2 CCH Trade Cas. ¶ 63,395 (4th Cir. 1980). Nonetheless, the Fourth Circuit did not follow the standard of liability promulgated by the Ninth Circuit. Instead, it examined the challenged restrictions and held them unlawful under the rule of reason as enunciated in

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[39] *Cf., Group Life & Health Ins. Co. v. Royal Drug Co.*, 440 U.S. 205 (1979). *See* Havighurst, *Controlling Health Care Costs*, J. Health Politics, Policy & Law 471 (1977).

[40] *United States v. Texas State Bd. of Public Accountancy*, 464 F. Supp. 400, 402-403 (W.D. Tex. 1978), *aff'd*, 592 F.2d 919 (5th Cir.), *cert. denied*, 444 U.S. 925 (1979) (state board's rule against competitive bidding by accountants held unlawful *per se*. *Accord, Feminist Women's Health Center v. Mohammad, Inc.*, 586 F.2d 530, 546-547 (5th Cir. 1978), *cert. denied*, 444 U.S. 924 (1979) (*per se* rule applicable to group boycott of abortion clinic by medical doctors).

[41] *United States v. National Society of Professional Engineers*, 555 F.2d 978 (D.C. Cir. 1977), *aff'd*, 435 U.S. 679 (1978) (professional society's ethical rule against competitive bidding held unlawful *per se*.)

[42] *See also United States v. Utah Pharmaceutical Ass'n*, 201 F. Supp. 29 (D. Utah), *aff'd*, 371 U.S. 24 (1962) (pharmaceutical association's fee schedule held unlawful *per se*); *Veizaga v. National Bd. of Respiratory Therapy*, 1977-1 CCH Trade Cas. ¶ 61,274 (N.D. Ill. 1977) (commercial practices of professional organizations held subject to *per se* liability).

National Society of Professional Engineers v. United States, 435 U.S. 679 (1978).

Thus, the circuit courts are now in conflict regarding the Sherman Act's application to doctors, with the Fifth Circuit and District of Columbia Circuit applying a *per se* rule to appropriate commercial practices of all professions, the Fourth Circuit rejecting a learned profession exemption but applying a truncated rule of reason analysis to the medical profession, and the Ninth Circuit creating an unprecedented standard of liability for the medical profession.

C. The Uncertainty Generated by the Ninth Circuit's Opinion Concerning the Sherman Act's Application to Physician Fee Schedules Should Be Resolved.

The anticompetitive consequences of fee schedules adopted by physician trade associations has aroused the concern of this Court[43] as well as the Congress,[44] the executive branch,[45] and numerous commentators.[46] Informed legal scholars have unanimously concluded that profes-

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[43] *Group Life & Heath Ins. Co. v. Royal Drug Co.*, 440 U.S. 205, 232 n. 40 (1979), and 440 U.S. at 253 (Brennan, J., dissenting).

[44] *E.g., Skyrocketing Health Care Costs: The Role of Blue Shield*, Hearing before the Subcommittee on Oversight and Investigations of the House Committee on Interstate and Foreign Commerce, 95th Cong., 2d Sess., 4-34 (1978).

[45] *E.g., American Medical Ass'n*, No. 9064 (FTC, Nov. 13, 1978) (initial decision); Kass & Paulter, Federal Trade Commission Staff Report on Physician-Control of Blue Shield Plans (November 1979); Council on Wage and Price Stability, *Physicians' Fees, A Study of Physicians' Fees* (1978) (Exhibit 2 to CR 66).

[46] *See* notes 47 and 48 *infra*.

sional price restraints,[47] including the very foundation fee schedules challenged here,[48] are and should be unlawful *per se*.

In *Group Life & Health Ins. Co. v. Royal Drug Co.*, 440 U.S. 205 (1979), this Court only recently held that provider fee agreements are subject to the Sherman Act. There, both the majority and dissenting opinions expressed concern over the anticompetitive impact of provider agreements that are dominated by physician trade associations.[49] Now the Ninth Circuit has created a judicial exemption for those very agreements on the hypothesis that the health care market has been so distorted by anticompetitive influences that established antitrust standards cannot be applied to it. (*See* Appendix A at 6; *compare with* Appendix A at 23-33 (Larson, J., dissenting.)) In defining the issue before it as "the attainment of the monopolist's goal" rather than the attainment of the Sherman Act's goal, the Ninth Circuit departed radically from this Court's construction of the Sherman Act and substituted its judgment for that of the Congress.

The uncertainty generated by Judge Sneed's opinion is particularly unfortunate because the question at issue is of grave public concern. Medical care costs account for more that 10 percent of the Gross State Product of Arizona, and disproportionate increases in those costs have distorted the

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[47] Havighurst, and Kissam, *The Antitrust Implications of Relative Value Studies in Medicine*, J. Health Politics, Policy and Law 48, 75-77 (Winter 1979); Horan and Nord, *Applications of Antitrust Law to the Health Care Delivery Systems*, 9 Cumberland L. Rev. 685, 700 (1979); Canby and Gellhorn, *Physician Advertising: The First Amendment and the Sherman Act*, 1978 Duke L.J. 543, 578; Havighurst, *Professional Restraints on Innovation in Health Care Financing*, 1978 Duke L.J. 303; Weller, *Medicaid Boycotts and Other Maladies from Medical Monopolists*, 11 Clearninghouse Rev. 99, 104 (1977); Note, *The Professions and Noncommercial Purposes*, 11 U. Mich. J. of Law Reform 387 (1978).

[48] Kallstrom, *Health Care Cost Control by Third Party Payors; Fee Schedules and the Sherman Act*, 1978 Duke L.J. 645.

[49] 440 U.S. at 232 n. 40; 440 U.S. at 253 (Brennan, J., dissenting).

State's economy.[50] The hardship borne by those citizens unable to obtain medical care at the artificial price level established by these fee schedules is unrecoverable and irreparable.[51] Only by the cruelest form of irony can the anticompetitive, inflationary characteristics of the health care market serve as the basis for a special rule of law which undercuts the antitrust remedies Congress has afforded to those citizens.

CONCLUSION

For the above reasons, petitioner respectfully submits that this petition for writ of certiorari should be granted.

Respectfully submitted,

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[50] Arizona Dept. of Health Services, *State Health Plan of Arizona* (Fiscal Year 1977), Exhibit D to CR 68; CR 13, 14, 109.

[51] The court of appeals recognized the irreparable nature of that harm when it granted Arizona's motion for a stay pending appeal and enjoined respondents from establishing or disseminating new fee schedules. (Order of August 31, 1979. (Judges Choy and Wallace). *See Valenciano v. Bateman*, 323 F.Supp. 600, 603 (D. Ariz. 1971). *Cf., Memorial Hospital v. Maricopa County*, 415 U.S. 250, 259-61 (1974).

APPENDIX

Filed—MAR 20 1980
Richard H. Deane, Clerk
U.S. Court of Appeals

United States Court of Appeals
For the Ninth Circuit

No. 79-3427

STATE OF ARIZONA,

Plaintiff-Appellant,

vs.

MARICOPA COUNTY MEDICAL SOCIETY, an Arizona non-profit corporation; MARICOPA FOUNDATION FOR MEDICAL CARE, an Arizona non-profit corporation; and PIMA FOUNDATION FOR MEDICAL CARE, an Arizona non-profit corporation,

Defendants-Appellees.

No. 79-3612

STATE OF ARIZONA,

Plaintiff-Appellant,

vs.

MARICOPA COUNTY MEDICAL SOCIETY, an Arizona non-profit corporation; MARICOPA FOUNDATION FOR MEDICAL CARE, an Arizona non-profit corporation, and PIMA FOUNDATION FOR MEDICAL CARE, an Arizona non-profit corporation,

Defendants-Appellees.

OPINION

Appeal from the United States District Court
for the District of Arizona

Before: SNEED and KENNEDY, Circuit Judges, and LARSON,* District Judge.

SNEED, Circuit Judge:

These consolidated appeals derive from the plaintiff-appellant's injunctive suit[1] to halt alleged antitrust violations by the defendants-appellees, two foundations for medical care (FMCs),[2] and the county medical society associated with one of them. The challenged conduct is the setting by majority vote of maximum fees that physician members may claim in full payment for health services they provide to policyholders of FMC-approved insurance plans. The appellant State of Arizona appeals from the vacation of a temporary restraining order that had already been extended without a hearing beyond the usual period. It also appeals from denial of summary judgment on the issue of liability. Pursuant to 28 U.S.C. § 1292(b) the district court certified the question whether the FMC membership agreements, which contain the promise to abide by maximum fee schedules, are illegal per se under section 1 of the Sherman Act, 15 U.S.C. § 1. We have jurisdiction to answer the certified question, but do not reach the jurisdictional issue raised by the other appeal. We affirm.

I. FACTUAL BACKGROUND

The FMCs in this case exemplify a type of organization that is beginning to play a significant part in the health services market. *See* C. Steinwald, An Introduction to Foundations for Medical Care (1971); Havighurst, *Professional Restraints on Innovation In Health Care Financing*, 1978 Duke L.J. 303, 315-16. The two challenged FMCs are not-for-profit corporations licensed as "insurance administrators" by the State of Arizona. Their activities include

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[1] Uniform State Antitrust Act. Ariz. Rev. Stat. Ann. § 44 1402.

[2] The Pima County Medical Society was also originally joined as a party but has been dismissed from the suit under a consent order.

polling their members from time to time to set upper limits on fees they may charge patients covered by insurance plans the FMCs approve. This "price fixing," the FMCs claim, subserves a general purpose of setting minimum standards and performing peer review and administrative tasks for health insurance plans. Under the heading of peer review, the foundations evaluate the medical necessity and appropriateness of treatment given and, in some instances, the use of hospital services. They also serve as agents for the underwriters, drawing funds directly from insurers' bank accounts to pay doctor's bills. Participation in the foundations is open to all physicians licensed in Arizona.

The State of Arizona charges that the foundations' fee schedules have raised members' fees above the average and median fees charged by Arizona doctors. The foundations dispute the appropriateness of the statewide figures used for the comparison, but concede that eighty-five to ninety-five percent of physicians in Maricopa County bill at or above the maximum reimbursement levels set by the county FMC.[3] The foundations point out that the State's own maximum reimbursement levels for its worker's compensation insurance program and Comprehensive Medical/Dental Program for Foster Children are higher than the foundations'. Although the State primarily argues that the FMC membership agreements are contracts to fix prices, it hints that the FMCs serve a separate anticompetitive end by aiding the exchange of price information among doctors in the counties concerned. The State contends that the FMC fee schedules are not inseparable from the professional standards review of FMC-approved insurance plans, since the foundations offer peer review and administrative services for at least one health program—the foster child program—in which prices paid the doctors are not set by themselves but by the third party payor. Although the foundations say their purpose is to provide an alternative to

[3] The record is silent concerning the comparison of Pima County FMC fee schedules with statewide average and median fees.

"closed panel prepaid health insurance plans," which are sometimes called "health maintenance organizations" (HMOs), *see* Havighurst, *Health Maintenance Organizations and Market for Health Services*, 35 Law & Contemp. Prob. 716 (1970), the record does not show that HMOs exist in Maricopa or Pima County or have been kept from entering the health service market in those counties by the operation of the FMCs.

II. THE NO. 79-3612 APPEAL.

Our jurisdiction to consider the appeal in No. 79-3427 is based on 28 U.S.C. § 1292(b). As for the appeal in No. 79-3612, we note that the State of Arizona would be entitled to reinstatement to an originally proper preliminary injunction only if the court below, in dissolving it, had committed an abuse of discretion. The controlling standard is a sliding scale correlation of the "balance of hardships" with the likelihood that a permanent injunction will be granted. *Benda v. Grand Lodge of International Association of Machinists*, 584 F.2d 308, 314-15 (9th Cir. 1978), *cert. dismissed*, 99 S.Ct. 2065 (1979); *William Inglis & Sons Baking Co. v. ITT Continental Baking Co.*, 526 F.2d 86, 88 (9th Cir. 1975). The State argued that without preliminary relief, its citizens would suffer pecuniary loss, and prospective patients who could not afford a physician's care at supracompetitive prices would suffer physical injury and mental distress. On the other hand, a preliminary injunction threatened the very existence of the FMCs. Given this balance of hardships and the uncertainties attending proof of the antitrust violation, which we consider below, we cannot say that the district court would have erred in dissolving a preliminary injunction.

III. THE NO. 79-3427 APPEAL.

A.

We must approach this appeal mindful that the Supreme Court has made it clear that the determination whether an agreement violates the Sherman Act turns on its "impact on competitive conditions." *National Society of Profes-*

sional Engineers v. United States, 435 U.S. 679, 688 (1978). The fact that a restraint may for one or more reasons appear reasonable is not controlling. An unreasonable restraint that contravenes the Sherman Act may be "based either (1) on the nature and character of the contracts, or (2) on surrounding circumstances giving rise to the inference or presumption that they were intended to restrain trade and enhance prices." *Id.* at 690 (footnote omitted). The key, to repeat, is the agreement's impact on competition. If competition is promoted the agreement passes muster; if it suppresses or destroys competition it does not. Some agreements so often lack redeeming virtue, so frequently suppress or destroy competition, as to warrant their classification as per se unreasonable. *Broadcast Music, Inc. v. Columbia Broadcasting Co.*, 99 S.Ct. 1551, 1554 (1979). Once so classified a violation of the Sherman Act is made out merely by proving that such an unworthy agreement exists. Actual proof of its competitive impact is unnecessary. It is presumed to be anticompetitive.

The State of Arizona insists that the practice of setting maximum fees by majority vote of the members of the FMC constitutes an arrangement without redeeming virtue that suppresses and destroys competition and is thus unreasonable per se. The difficulty with Arizona's position is that this record reveals nothing about the actual competitive effects of the challenged arrangement nor do the authorities, primary or secondary, afford assurance concerning its competitive impact. In truth, we know very little about the impact of this and many other arrangements within the health care industry. This alone should make us reluctant to invoke a per se rule with respect to the challenged arrangement.

There are, however, additional reasons. Foremost among them is that we are uncertain about the competitive order that should exist within the health care industry pursuant to the Sherman Act as interpreted by the courts. Only recently have the professions been brought by the Supreme Court within the reach of the Act. *Goldfarb v. Virginia*

State Bar, 421 U.S. 773, 785-88 (1975). The guidelines by which each is govered pursuant to the Act are being written on a case by case basis.

The health care industry, moreover, presents a particularly difficult area. The first step to understanding is to recognize that not only is access to the medical profession very time consuming and expensive both for the applicant and society generally, but also that numerous government subventions of the costs of medical care have created both a demand and supply function for medical services that is artifically high. The present supply and demand functions of medical services in no way approximate those which would exist in a purely private competitive order. An accurate description of those functions moreover is not available. Thus, we lack baselines by which could be measured the distance between the present supply and demand functions and those which would exist under ideal competitive conditions.

Perforce we must take industry as it exists, absent the challenged feature, as our baseline for measuring anticompetitive impact. The relevant inquiry becomes whether fees paid to doctors under that system would be less than those payable under the FMC maximum fee agreement. Put differently, confronted with an industry widely deviant from a reasonably free competitive model, such as agriculture, the proper inquiry is whether the practice enhances the prices charged for the services. In simplified economic terms, the issue is whether the maximum fee arrangement better permits the attainment of the monopolist's goal, *viz.*, the matching of marginal cost to marginal revenue, or in fact obstructs that end.

Approached in this manner, the weakness of Arizona's suggestion that a per se rule be employed here becomes apparent. To assume that the arrangement in question wrongfully increases fees requires the further assumption that the FMCs are but devices to enable the member doctors to capture a greater share of potential monopoly profit,

which their monopoly power makes available, than otherwise would be possible. This is an assumption we are not prepared to make on the basis of the record before us.

Our reluctance also has other roots. We are not, for example, prepared to believe without some evidence that a conspiratorial exploitation of monopoly power by the doctors would be supinely accepted by the insurance carriers. Nor are we prepared to reject out of hand the claim that a ceiling on fees does in fact reduce them. No one suggests that peer review is suspect, although it too purports to reduce the aggregate costs of medical services by curtailing unnecessary treatment. If it is proper to assume a conspiratorial exploitation with respect to maximum fees, why should a different assumption be applicable to peer review? Our belief is that neither assumption is appropriate.[4]

We are by no means unaware that economic motives frequently lie behind even the best of good works. We are, however, simply not prepared to brand the appellee's conduct as "price-fixing" and thus a per se violation of the Sherman Act on the basis of an unsupported *belief* that fee enhancement is the likely consequence of the appellees' maximum fee arrangement. We say this in full recognition that the appellee's conduct involves some exchange of price information from which an agreement to raise or maintain

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[4] Two Supreme Court decisions have held maximum resale price agreements to be illegal per se. *Albrecht v. Herald Co.*, 390 U.S. 145 (1968); *Kiefer-Stewart Co. v. Joseph E. Seagram & Sons*, 340 U.S. 211 (1951); *see also Quinn v. Mobil Oil Co.*, 375 F.2d 273 (1st Cir.), *cert. dismissed*, 389 U.S. 801 (1967). This circuit has not extended those rulings to horizontal agreements that establish maximum prices. For an argument that the extension is proper, see L. Sullivan, Antitrust 210 (1977). A consequence of the extension, however, would be to moot an aspect of the currently lively debate concerning "limit pricing" and predatory price-cutting. It can hardly be said, then, that a per se rule forbidding horizontal maximum price agreements is well settled. It is arguable that this case does not present the issue for our decision. The FMC membership agreements do not set price ceilings for given services across the board but only limit the fees recoverable from certain patients, namely, those covered by FMC-approved insurance policies.

prices might be implied if sufficient corroborative facts were shown. *See American Column & Lumber Co. v. United States*, 268 U.S. 563, 586 (1925). An agreement of that nature properly proven would violate section 1 of the Sherman Act. To affix the per se label to appellees' conduct is, however, once more to substitute an unsupported belief for proper proof.

We acknowledge that it is quite possible, perhaps even probable, that the price ceiling serves the purpose of forestalling government price control that could force prices to an even lower level. This does not make the ceiling a violation of the Sherman Act. To eschew profit maximization in order to forestall price control is neither irrational nor, under the facts of this record, in violation of the Act. We observe in passing that only a government lost in an impenetrable legal maze, after having contributed substantially to the creation of monopoly conditions, would threaten price control if full monopoly profits are reaped and enforcement of the antitrust laws if private means are used to prevent the harvest.

B.

Appellant argues that our position is impermissible because under *United States v. Socony-Vacuum Oil Co.*, 310 U.S. 150, 221 (1940), any collective effort to "tamper with price structures" offends antitrust policy. The argument, while by no means fanciful, overlooks *Broadcast Music* which held that a traditional form of minimum price fixing in the market for music under copyright was not illegal per se. *Broadcast Music* reminds us that whether to classify something as " 'per se price fixing' " will often, but not *always*, be a simple matter." 99 S.Ct. 1557 & n.14 (emphasis added).

The issue whether to so classify the price schedules in this case is by no means "a simple matter." In addition to the uncertainties already referred to, we do not know how health insurers such as Blue Cross fix their fee schedules in the relevant geographical area or whether the fees they of-

fer exceed the appellees' maximum fees. We are not informed by the record of the identity of, or the role played by, the various institutional components that compete in the relevant market. One may guess that doctors, both within and without the FMC structure, insurance carriers, hospitals, and perhaps HMOs, operate within the market; nonetheless, the record reveals nothing about the nature and extent of the competition, between them. This makes it impossible to evaluate the pro- and anticompetitive aspects of a given feature of the total structure, although these aspects must be weighed together in determining whether a per se rule, or even the Rule of Reason, should brand the questioned feature illegal.[5]

Our unwillingness to employ a per se rule in this case is not overcome by the suggestion of a well-informed commentator that FMCs could and, perhaps in some instances, have unfairly prevented HMOs from recruiting subscribers and thus gaining entry to the relevant health service market. Havighurst. *Health Maintenance Organizations and the Market for Services*, 35 Law & Contemp. Prob. 716, 767-76 (1971). The thought is that FMCs, far from extracting the maximum profit possible, have set fees sufficiently low to discourage entry by potential competitors such as HMOs. *See Knutson v. Daily Review, Inc.* 548 F.2d 795, 814 n.21 (9th Cir. 1976) ("If the fixed maximum price is higher than cost but lower than a price that would permit new entrants or smaller scale competitors to operate (i.e., a 'limit price'), then, although not predatory, it could support other efforts to acquire a monopoly") (dictum). Some have questioned

[5] When a questioned business practice affects more than one sphere of competition, the Rule of Reason of course recognizes that the enhancement of competition in one sphere may offset the weakening of competition in another. Sometimes, for example, "both interbrand and intrabrand competition must be considered . . ." *First Beverages, Inc. v. Royal Crown Cola Co.*, Nos. 77-3536, 78-1050 (9th Cir. Jan. 30, 1980), slip op. at 1809 n.8, although not every case requires extensive analysis of these multiple effects or jury instructions concerning them. *Id* at 1809-11. Here the novelty of the market or markets and the inadequacy of the record make an inquiry into the affected areas of competition essential.

the theory on which the thought rests. *See* RF. Posner, Antitrust Law: An Economic Perspective 115 n.50 (1976); for a detailed critique of the limit-price theory, *see* Markovits, *Potential Competition, Limit Price Theory, and the Legality of Horizontal and Conglomerate Mergers Under the American Antitrust Laws*, 1975 Wis.L.Rev. 658. Doubt springs from the fact that the returns to those possessing monopoly power from pursuing a policy of fixing prices sufficiently low to discourage the entry of competitors are likely to be less over the long run than those resulting from a pricing policy that permits the capture of monopoly profits. In the latter case, high profits likely will draw competitors whose entry will drive prices down to a point approximating that which would have been set by a policy designed to bar entry. Thus, either policy over time yields approximately the same price level, the difference being that in the latter case available monopoly profits were captured while in the former they were foregone. Knowingly to forego such profits is irrational. This so-called "limit-price" theory, therefore, cannot be accepted as the foundation of a per se rule.

Our conclusion in this regard does not conflict with the general disapproval of predatory practices, of which predatory pricing is the most commonly examined species. *See, e. g., Utah Pie Co. v. Continental Baking Co.*, 386 U.S. 685 (1967); R. Posner, Antitrust Law: An Economic Perspective 184-96 (1976); L. Sullivan, Handbook of the Law of Antitrust 108-13 (1977); Areeda & Turner, *Predatory Pricing and Related Practices Under Section 2 of the Sherman Act*, 88 Harv. L.Rev. 697 (1975); Cooper, *Attempts and Monopolization: A Mildly Expansionary Answer to the Prophylactic Riddle of Section Two*, 72 Mich.L.Rev. 373, 435-40 (1974); Williamson, *Predatory Pricing: A Strategic and Welfare Analysis*, 87 Yale L.J. 284 (1977). As these authorities illustrate, however, there is nothing like agreement concerning the signs by which predation is

identifiable.[6] Without deciding what the proper identifying signs may be, we are confident that none is revealed by this record. Moreover, the evil of predatory pricing is that it makes possible an ultimate capture of monopoly profits. Were prices maintained at the predatory level indefinitely the case against predatory pricing would more resemble that against suicide than that against monopolies.

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[6] There is no disagreement about what constitutes predatory pricing. It is "pricing at a level calculated to exclude from the market an equally or more efficient competitor," R. Posner, *supra*. at 188, "conduct which has the purpose and effect of advancing the actor's competitive position, not by improving the actor's market performance, but by threatening to injure or injuring [competitors], so as to drive them or keep them out of the market, or force them to compete less effectively," L. Sullivan, *supra*, at 108. But while this definition of predatory behavior stresses anticompetitive intent, business tactics are exceptionally resistant to state-of-mind analysis. Antitrust theorists have therefore gravitated toward purely economic definitions. For example, Areeda and Turner propose that the courts regard as predatory pricing, policies that yield returns below average or marginal cost, whichever is lowest. Areeda & Turner, *supra*. Since marginal and average cost include a normal return on capital, however, the difficulties of determining the normal return for the firm in question make this proposal a demanding one for the courts to implement. *See* L. Sullivan, *supra*, at 110; R. Posner, *supra*, 191-93. Posner believes that a modified form of the below-cost pricing criterion is appropriate. *Id* at 188-91 Although this court has entertained the possibility of proving predation by marginal or average cost statistics, *Hanson v. Shell Oil Co.* 541 F.2d 1353 (9th Cir. 1976), we have not held that mode of proof to be exclusive, *Id.* at 1358 ("[Predatory pricing] *could* be shown by evidence" of below cost pricing (emphasis added)); *cf. Janich Bros., Inc. v. American Distilling Co.*, 570 F.2d 848, 858 (9th Cir. 1977). *cert. denied.* 439 U.S. 829 (1978) ("Thus, as stated in *Hanson*, average variable cost can be used as evidence of marginal cost."). More recently, the court has recognized "that refinement of the marginal or average variable cost test will be necessary as future cases arise." *California Computer Products, Inc. v. International Business Machines Corp.*, No. 77-1563 (9th Cir. June 21, 1979), slip op. at 2191 (citing Williamson, *supra*, among other recent commentators on predatory pricing). Since there is no contention before us that predation has occured, we note only that our skepticism about limit-pricing in no way discredits theories of predation.

Our holding does not conflict with *Group Life and Health Insurance Co. v. Royal Drug Co.* 99 S.Ct. 1067 (1979). The practice of which the appellant complains in this case is not "the business of insurance." No more was held with respect to the practice involved in *Royal Drug.* The issue whether that practice violated the antitrust laws expressly was not decided. Here we confront precisely that type of issue and merely hold that the challenged practice is not a per se violation.

We conclude by observing that we draw comfort from the Supreme Court's reiteration in *National Society of Professional Engineers,* 435 U.S. at 696, n.22 of its statement in *Goldfarb v. Virginia State Bar,* 421 U.S. 773 (1975) that marketing restraints that regulate professional competition may pass muster under the Rule of Reason even though similar restraints on ordinary business competition would not. We believe this recognizes that a restraint may serve the public, the transcendent end of all professions, even though its presence in a purely commercial setting would violate the antitrust law. *See Professional Engineers, supra,* 435 at 696 & n.22; *Boddicker v. Arizona State Dental Ass'n.,* 549 F.2d 626 (9th Cir. 1977). There is sufficient probability of the challenged practice in this case being sheltered by this principle to justify our refusal to brand it as a per se violation.

Affirmed.

KENNEDY, Circuit Judge, concurring:

I agree with my Brother Sneed that we know too little about the effects on competition produced by the practices here in question to brand them per se violations of the Sherman Act at this point. "It is only after considerable experience with certain business relationships that courts classify them as *per se* violations ..." *United States v. Topco Associates, Inc.* 405 U.S. 596, 607-08 (1972). We lack that experience in judging the maximum reimbursement schedules present here; and I am unable, for the reasons set forth in Judge Sneed's opinion, to say that these

schedules "on [their] face [have] the effect, or could have been spurred by the purpose, of restraining competition among the individual [physicians]." *Broadcast Music, Inc. v. Columbia Broadcasting System, Inc.*, 441 U.S. 1, 13 (1979); *Northern Pac. R. Co. v. United States*, 356 U.S. 1 (1958).

While the Supreme Court has rejected any blanket antitrust exemption for learned professions, *see, e. g., Goldfarb v. State Bar*, 421 U.S. 773, 785-88 (1975), it has indicated that the antitrust laws may have somewhat different applications to some trade practices in those areas. *See, e. g., National Society of Professional Engineers v. United States*, 435 U.S. 679, 696 n.22 (1978). Per se rules should be derived from considerations of economic impact in particular cases illustrating the category of prohibited acts, and therefore a trial is appropriate to explore further the impact on competition of the challenged reimbursement schedules.

This is not to suggest, however, that I have found these reimbursement schedules to be per se proper, that an examination of these practices under the rule of reason at trial will not reveal the proscribed adverse effect on competition, or that this court is foreclosed at some later date, when it has more evidence, from concluding that such schedules do constitute per se violations. The evidence adduced at trial may very well show that the theories which Judge Sneed refutes in the abstract do have an empirical foundation and that the challenged practices have the proscribed effect of suppressing rather than promoting competition. *See National Society of Professional Engineers v. United States, supra*, 435 U.S. at 691.

There does not now appear to be a controlling or definitive analysis of the market impact caused by the arrangements under scrutiny in this case, but trial may reveal that the arrangements are, at least in their essentials, not peculiar to the medical industry and that they should be condemned. For the foregoing reasons I concur.

LARSON, Senior District Judge (dissenting).

I respectfully dissent from the majority decision. The defendants' conduct constitutes price-fixing that is per se illegal under the Sherman Act. In addition, the trial court abused its discretion in refusing to continue or grant the preliminary injunction.

I.

We are presented with two consolidated appeals by the State of Arizona. No. 79-3427 was brought pursuant to 28 U.S.C. § 1292(b). The controlling question of law certified was whether the challenged practice should be judged under a per se rule or by the rule of reason. No. 79-3612 is an appeal from a district court order of July 17, 1979, which in essence was a refusal to continue an injunction. The majority opinion reaches only the first appeal, noting, however, that it cannot be said that "the district court would have erred in dissolving a preliminary injunction." I believe both appeals can and must be treated fully.

The complaint in this action was filed on October 17, 1978. Arizona moved for a preliminary injunction on October 25, 1978, but no hearing was held on this motion before the events which led to these appeals. On November 2, 1978, the parties agreed to an order establishing the sequence of discovery and pretrial motions. Paragraph 6 of this order forbade the defendants from engaging in allegedly illegal practices until the preliminary injunction motion was heard, or May 1, 1979, or until further order of the court. On April 20, 1979, Arizona moved to maintain the status quo past May 1, 1979. Defendants objected, but on April 30, 1979, the trial judge decided that Paragraph 6 of the November 2, 1978, order would remain

in effect pending further order of the court. In a June 5, 1979, order and memorandum, defendants' motion to dismiss the complaint and plaintiff's motion for summary judgment on the issue of liability were denied by the district court. It was in this order that the district judge stated that the challenged conduct would be analyzed under the rule of reason rather than by a per se rule.

Following this decision, the defendants moved to vacate the April 30 order. On July 17, 1979, the district court granted this request. The district court appeared to view the continuation of Paragraph 6 of the November 2, 1978, order as either a temporary restraining order or "because of the lapse of time and the preparation of the parties, as an application for a preliminary injunction."

This July 17, 1979, order was appealed pursuant to 28 U.S.C. § 1292(a)(1), which allows review of interlocutory orders "granting, continuing, modifying, refusing or dissolving injunctions, or refusing to dissolve or modify injunctions." Grants or denials of temporary restraining orders are not appealable under this statute. *In the Matter of Vuitton et Fils S.A.*, 606 F.2d 1, 3 (2d Cir. 1979); *Levesque v. State of Maine*, 587 F.2d 78, 79 (1st Cir. 1978); *Sohappy v. Smith*, 529 F.2d 570, 572 (9th Cir. 1976); 9 Moore's Federal Practice ¶ 110.20[5] (2d ed. 1975). However, often the characteristics and circumstances of an order, not how it is denominated, determine whether it is appealable. *See Sampson v. Murray*, 415 U.S. 61, 85-88 (1974); *Melanson v. John J. Duane Co.*, 605 F.2d 31, 33 (1st Cir. 1979); *Clements Wire & Mfg. Co. v. NLRB*, 589 F.2d 894, 896-97 (5th Cir. 1979); Moore's Federal Practice, *supra*. This order was continued for over eight months. That fact alone might require that it be treated as a preliminary injunction. *See Sampson v. Murray*, *supra*, at 86. The district court believed it could be so viewed, and the defendants, when requesting vaction of the order, argued that it was in

effect a preliminary injunction. In addition, there had already been extensive consideration of the merits by the district court. The July 17 order was the denial or dissolution of a preliminary injunction and is therefore appealable.

The general standard for reviewing grants or denials of preliminary injunctions is whether the trial court abused its discretion. *Miss Universe, Inc. v. Flesher,* 605 F.2d 1130, 1132-33 (9th Cir. 1979); *City of Anaheim v. Kleppe,* 590 F.2d 285, 288 n.4 (9th Cir. 1978). A decision based on an erroneous legal premise would also be reversible. *Miss Universe. Inc. v. Flesher, supra; Kennecott Copper Corp., v. Nevada,* 572 F.2d 1349, 1357 n.3 (9th Cir. 1978); *Klaus v. Hi-Shear Corp.,* 528 F.2d 225, 231 (9th Cir. 1975). *See Chromalloy American Corp. v. Sun Chemical Corp.,* Nos. 79-1741, 79-1757, slip op. at 7 (8th Cir. Dec. 14, 1979); *State of Kansas ex rel. Stephan v. Adams,* 608 F.2d 861, 867 n.5 (10th Cir. 1979); *Jack Kahn Music Co. v. Baldwin Piano & Organ Co.,* 604 F.2d 755, 758 (2d Cir. 1979). As discussed in detail below, I believe the district court was legally wrong in declining to apply a per se rule to defendants'

conduct.[1] Even if the district court was correct in applying the rule of reason, it was, however, an abuse of discretion to refuse to prolong the injunction and the status quo.

The test for awarding preliminary injunctions has undergone considerable evolution in recent decisions.[2] This history is traced in *City of Anaheim v. Kleppe, supra.* Currently there are two tests which are viewed as the extremes

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[1] Although the district court's June 5, 1979, memorandum is well reasoned, it displays a misperception of the current state of antitrust analysis. The district court felt that per se rules were being supplanted by greater use of the rule of reason. A careful survey of recent decisions discloses that not only are per se rules continuing to be applied in traditional areas like price-fixing, but they are also being extended to encompass new anticompetitive practices. The Supreme Court has continually reaffirmed the value of per se rules, especially when applied to conduct affecting pricing. Maximum price-fixing clearly has been and should be regarded as per se illegal, particularly in a horizontal context. *See* text, *infra* at p. 4. The Kallstrom article referred to by the district court takes the position that maximum price setting among individual medical providers should be per se illegal, especially when done by a Foundation for Medical Care. Kallstrom, *Health Care Cost Control by Third-Party Payors,* 1978 Duke L.J. 645, 680-83. Finally, the district court felt that professionals were accorded special treatment under the antitrust laws. Supreme Court and other decisions, however, indicate that when commercial practices of a profession are at issue, per se rules may be applied, particularly if the challenged activity affects price. *See* text, *infra,* at pp. 5-6. The combined effect of all these errors requires that the district court at least be ordered to reconsider its refusal to continue the preliminary injunction.

[2] I have concentrated on the general standards for preliminary injunctions but it should be noted that § 16 of the Sherman Act, 15 U.S.C. § 26, also governs preliminary relief under the antitrust laws. Much of the procedural difficulty here could have been avoided by closer adherence to the requirements of Rule 65 of the Federal Rules of Civil Procedure, particularly after defendants objected to the April 30 continuation of Paragraph 6.

of a continuum.[3] The moving party must show either (1) probable success on the merits and possible irreparable injury or (2) sufficiently serious questions going to the merits to create a fair ground for litigation and a balance of hardships tipping decidedly toward the moving party. *Anderson v. United States*, No. 77-3222, slip op. at 1022 (9th Cir. Nov. 28, 1979); *Miss Universe, Inc. v. Flesher, supra*, at 1134. As the balance of hardships increases in favor of the moving party, the necessity of showing a likelihood of success on the merits decreases. *City of Anaheim v. Kleppe, supra*. A final factor present in the decision whether to award preliminary relief is an evaluation of where the public interest lies. *City of Anaheim v. Kleppe, supra*.

The district judge declined to continue the injunction because he thought the balance of harms favored defendants. The defendant Foundations claimed only that physicians were threatening to withdraw if they could not increase the fees they recovered from third-party payors. A simple alternative was available for defendants to preserve their membership and avoid injury. They could suspend the requirement that doctors accept the fee schedule amounts as the maximum payment for treatment of insurance-covered patients. The Foundations could continue to perform their other functions. The physicians who wished to raise their fees could do so, and would have no reason to leave the Foundations. In the event that a favorable result for the physicians is obtained in this litigation, the Foundations could proceed to establish a new fee schedule and

[3] This continuum approach has been utilized by several circuit courts of appeals. *See Chromalloy American Corp. v. Sun Chemical Corp., supra; Maryland Undercoating Co. v. Payne*, 603 F.2d 477, 481 (4th Cir. 1979); *Florida Medical Assoc. v. United States Dept. of Health*, 601 F.2d 199, 202 (5th Cir. 1979); *Jackson Dairy, Inc. v. H. P. Hood & Sons*, 596 F.2d 70, 72, 74 (2d Cir. 1979); *Citizens Energy Coalition of Ind. v. Sendak*, 594 F.2d 1158, 1162 (7th Cir. 1979); *Doe v. Colautti*, 592 F.2d 704, 706 (3rd Cir. 1979). One of these courts has suggested that the balance may also work in the opposite direction; the greater the movant's likelihood of success, the less the balance of harms must swing in his favor. *See Maryland Undercoating Co. v. Payne, supra, 481 n.8.*

reinstitute the requirement that its member physicians adhere to the schedule. This procedure would avoid the only harm a preliminary injunction would cause the defendant Foundations: loss of membership.

Arizona claimed that promulgation of a new fee schedule would mean substantial increases in medical costs for its residents. The district court believed that any harm to those whom Arizona represents could be compensated by money damages. Arizona is not seeking damages and in any event the expense of proving and disbursing the increased charges to individual patients would likely be greater than the amount of damages recovered. The additional medical costs to Arizona citizens would be unrecoverable and irreparable. The balance of harms tips strongly in Arizona's favor. In addition, the public interest would best be served by continuing to enjoin the defendants' from preparing and using a new fee schedule. The fact that it is Arizona, the primary regulator or the health industry in that State and guardian of its citizens' interests, which has challenged defendants' conduct is also entitled to weight.

The district court also felt Arizona had not established a likelihood of success under the rule of reason, but it appears to me that plaintiff has shown a strong probability of success, even if forced to proceed under this standard. Fee-setting in this context is so obviously anticompetitive that it must be found to violate the Sherman Act. It is unquestioned that Arizona has at least raised serious questions about the legality of defendants' behavior. Therefore, wherever one chooses to stop along the continuum of preliminary injunction factors, Arizona is entitled to relief.

II.

I turn now to the standard of liability by which the challenged activity should be measured. This inquiry can be handled most efficiently if guided by three questions. First, is this a type of "naked price restraint" which has previously been adjudged per se illegal? If so, then only some peculiarity of the health care industry can justify applica-

tion of a lesser standard. *See e. g., Silver v. New York Stock Exchange*, 373 U.S. 341, 347 (1963). Second, if this is not a form of conduct traditionally found to be per se illegal, does it possess such harmful features that it should now be declared per se illegal? *See, e. g., Broadcast Music, Inc. v. Columbia Broadcasting System, Inc.*, 441 U.S. 1, 19-20 n.33 (1979). Third, even if the rule of reason must be applied, is the practice so plainly anti-competitive that only a truncated rule of reason analysis need be carried out? *See, e. g., National Society of Professional Engineers v. United States*, 435 U.S. 679, 692 (1978). The third question is relevant here because if answered in the affirmative, the likelihood of plaintiff's success, and the propriety of granting preliminary relief, would be increased.

Defendants formulated and dispersed relative value guides and conversion factor lists which together were used to set an upper limit on fees received from third-party payors. It is clear that these activities constituted maximum price-fixing by competitors. Disregarding any "special industry" facts, this conduct is per se illegal. *Albrecht v. Herald Co.*, 390 U.S. 145, 151-53 (1968); *Kiefer-Stewart Co. v. Seagram & Sons*, 340 U.S. 211, 213 (1951); *Kartell v. Blue Shield of Mass., Inc.*, 592 F.2d 1191, 1193, n.2 (1st Cir. 1979); *Quinn v. Mobil Oil Co.*, 375 F.2d 273, 274, 276-78 (1st Cir.), *cert. dismissed*, 389 U.S. 801 (1967); *Crane Distributing Co. v. Glenmore Distilleries*, 267 F.2d 343, 345 (6th Cir. 1959); *Vandervelde v. Put & Call Brokers & Dealers Assoc.*, 344 F.Supp. 118, 134 (S.D.N.Y.1972). Precedent alone would mandate application of the per se standard.

I find nothing in the nature of either the medical profession or the health care industry that would warrant their exemption from per se rules for price-fixing. Although the Supreme Court has distinctly rejected a broad learned professions exemption from the antitrust laws, *National Society of Professional Engineers v. United States supra*, at 696; *Goldfarb v. Virginia State Bar*, 421 U.S. 773, 787 (1975), confusion remains over the extent to which these professions are or should be subject to per se rules. *See*

generally Bauer, Professional Activities and the Antitrust Laws, 50 N.D. Lawyer 570 (1975); Note, *The Professions & Non-commercial Purposes*, 11 U.Mich.J. of L. Reform 387 (1978); Note, *The Antitrust Liability of Professional Associations After Goldfarb*, 1977 Duke L.J. 1047.

In *Goldfarb*, the district court found fee-setting by attorneys to be per se illegal. 355 F.Supp. 491, 493 (E.D. Va. 1973). The Supreme Court stated that a "naked agreement was clearly shown, and the effect on prices is plain," and that "respondents' activities constitute a classic illustration of price fixing." 421 U.S. at 782, 783. Although not explicit, a valid interpretation of this language is that the Supreme Court agreed that the per se rule was applicable. Certainly this is not a rule of reason analysis. The Supreme Court did add a caveat that the "public service aspect, and other features of the professions, may require that a particular practice, which could properly be viewed as a violation of the Sherman Act in another context, be treated differently. We intimate no view on any other situation than the one with which we are confronted today." 421 U.S. 788-89 n.17. The situation with which the Court was confronted in *Goldfarb*—price-fixing—is the same practice challenged in this case.

National Society of Professional Engineers v. United States, supra, is also not totally explicit on the standard applied. Both the district court, 404 F.Supp. 457, 460-61 (D.D.C.1975), and the court of appeals, 555 F.2d 978, 983 (D.C.Cir. 1977), found the ban on competitive bidding to be per se illegal. Both courts believed this result was consonant with *Goldfarb*. The Supreme Court recognized that the lower courts had found the practice unlawful on its face, 435 U.S. at 686, and it agreed with that assessment, 435 U.S. at 692-693. The central lesson of the case appears to be that when the nature and character of an agreement among professionals is plainly anticompetitive, no extended analysis is necessary to find it forbidden under the Sherman Act. I believe that in the wake of *Goldfarb* and *National Society of Professional Engineers*, the Supreme

Court would be willing to apply per se rules to professional price tampering and that this Court should not hesitate to do so.

Such an approach would be in accord with the rulings of other courts. *See United States v. Texas State Board of Public Accountancy*, 464 F.Supp. 400, 402-03 (W.D.Tex. 1978) (competitive bidding ban is per se illegal), *aff'd*, 592 F.2d 919 (5th Cir.), *cert. denied*, 100 S.Ct. 262 (1979); *Veizaga v. National Board for Respiratory Therapy*, [1977-1] Trade Cases (CCH) 61,274 (N.D.Ill.1977) (per se rule applied to commercial activity of a profession). Commentators have suggested that the commercial aspects of the professions, including medicine, should be subject to customary per se rules. *See* Horan & Nord, *Application of Antitrust Law to the Health Care Delivery System*, 9 Cumberland L.Rev. 685, 700 (1979) Weller, *Medicaid Boycotts & Other Maladies from Medical Monopolists*, 11 Clearinghouse Rev. 99, 104 (1977); Note, *The Professions & Non-commercial Purposes, supra*, at 399 and n.36, 414-15. Several authors have advocated that price-fixing by physicians, including maximum fee-setting, be declared per se illegal. *See* Havighurst & Kissam, *The Antitrust Implications of R.V. Studies in Medicine*, 4 J. Health Politics, Policy & Law 48, 75 (1979); Horan & Nord, *supra*, at 709; Kallstrom, *Health Care Cost Control by Third-Party Payors*, 1978 Duke L.J. 645, 683.

The defendants' price-fixing has a wholly commercial nature and has no relation to any public service aspect of the medical profession, or to any other professional objective of the defendants; nor does it appear to be motivated by a desire to benefit consumers. Eliminating the fee-setting would not inhibit defendants from continuing to perform peer review, quality control, or other permissible

functions. These activities are entirely separable from the fee-setting. That physicians are the participants in this price-fixing scheme does not exempt it from per se illegality.

A second exemption which might be advanced is one for the health care industry. Of course, Congress has not provided such an exemption and the courts should be extremely reluctant to imply one. *Goldfarb v. Virginia State Bar, supra,* at 787. It is not necessary here to strike any broader rule than to deny special treatment to price-fixing by physicians. Whether other practices in the health care business are due deferential handling can be decided when those activities are placed at issue.

Much attention has recently been focused on health care delivery, with particular concern over the seemingly uncontrollable increases in health care costs. Congress has examined the serious problems existing in the industry and has studied the potential benefits of introducing competitive forces.[4] Government agencies also have shown interest in the competitive state of health care.[5] A number of articles and books have been written on the sub-

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[4] *See* Staff of Perm. Subcomm. on Investigations of Senate Govern. Affairs Comm., 96th Cong., 1st Sess., *California Relative Value Studies: An Overview* (Staff Study 1979); Staff of Subcomm. on Oversight & Investigations of House Comm. on Interstate & Foreign Commerce, 95th Cong., 2d Sess., *Conflicts of Interest on Blue Shield Boards of Directors* (Comm. Print 1978); *Skyrocketing Health Care Costs: The Role of Blue Shield:* Hearings Before the Subcomm. on Oversight & Investigation of the House Comm. on Interstate & Foreign Commerce, 95th Cong., 2d Sess. (1978); *Competition in the Health Services Market, Pts. 1-3:* Hearings Before the Subcomm. on Antitrust & Monopoly of Senate Comm. on the Judiciary, 93d Cong., 2d Sess. (1974).

[5] *See In the Matter of A.M.A.*, F.T.C. Docket No. 9064, Trade Reg. Rpts. No. 409, pt. II (CCH) Oct. 30, 1979); Federal Trade Commission. *Competition in the Health Care Sector* (1978) (collection of papers from F.T.C. conference); Kanwit, *FTC Enforcement Efforts Involving Trade & Professional Associations,* 46 Antitrust L.J. 640 (1978); Palmer, *Antitrust Activities By the FTC in the Health Field,* 37 Fed.B.J. 40 (1978) (lists FTC relative value guide cases on pages 46-47).

ject.[6] The Supreme Court has even noted the problem in a recent case, *Group Life & Health Ins. Co. v. Royal Drug Co.*, 440 U.S. 205, 232 n.40 (1979).[7]

The health care industry currently does not display significant competitive conditions. There are many reasons for this situation, including the tax laws, the effects of insurance, and, as the majority notes, governmental regulation and financial entanglement. It is also undoubtedly true that a major factor has been the active suppression of competition by traditional medical associations.[8] The restraints fostered by these groups are and should be subject to conventional antitrust scrutiny. Although market forces may be bridled in part by factors beyond the reach of the Sherman Act, this does not prevent utilization of the law to remove additional constraints which normally are illegal. Partial governance by competitive forces can create benefits even though anticompetitive forces remain in the market.

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[6] *See* P. Proger, *Antitrust in the Health Care Field* (1979); M. Thompson, *Antitrust & the Health Care Provider* (1979); Borsody, *The Antitrust Laws & the Health Industry*, 12 Akron L.Rev. 417 (1979); Havighurst, *Professional Restraints on Innovation in Health Care Financing*, 1978 Duke L.J. 314; Havighurst & Kissam, *supra;* Horan & Nord, *supra;* Kallstrom, supra; Kessel, *Price Discrimination in Medicine*, 1 J.L. & Econ. 20 (1958); Rosoff, *Antitrust Laws & the Health Care Industry*, 23 St. Louis, U. L.J. 446 (1979); Weller, *supra.* Note, *Application of Antitrust Laws to Anticompetitive Activities by Physicians.* 30 Rutgers L.J. 991 (1977).

[7] "[E]xempting provider agreements from the antitrust laws would be likely in at least some cases to have serious anticompetitive consequences. Recent studies have concluded that physicians and other health-care providers typically dominate the boards of directors of Blue Shield plans. Thus, there is little incentive on the part of Blue Shield to minimize costs, since it is in the interest of the providers to set fee schedules at the highest possible level. This domination of Blue Shield by providers is said to have resulted in rapid escalation of health-care costs to the detriment of consumers generally."

[8] See Havighurst, *supra*, at 315-321; Havighurst & Kissam, *supra*, at 58, 68; Kessel, *supra*, at 32; Palmer, *supra*, at 42-3.

It is not our task to determine what the competitive order should be. The Sherman Act requires that absent very unusual circumstances market forces should be given free rein. The policy decision that competition is in the public interest has been made by Congress and must be enforced by the courts. *National Society of Professional Engineers v. United States, supra,* at 692, 695. Furthermore, "[E]arly cases also foreclose the argument that because of the special characteristics of a particular industry, monopolistic arrangements will better promote trade and commerce than competition. That kind of argument is properly addressed to Congress . . ." *Id.* at 689 (cites omitted).

We are confronted here with a challenge to behavior usually found per se illegal under the antitrust laws. Nothing in the arguments advanced by defendants or by the majority opinion convinces me that application of the procompetitive policy of the Sherman Act to physician price-fixing will be harmful to the health care business or to its consumers. On the contrary, vigorous enforcement of the law could encourage new forms of health care delivery that would significantly benefit the public.[9] Some initial steps toward reform have been made in medicine. *See In the Matter of A.M.A.*, F.T.C. Docket No. 9064, Trade Reg. Rpts. No. 409 Pt. II (CCH) (Oct. 30, 1979) (forbidding advertising and price restraints). The majority opinion will hinder attempts by doctors, consumers and government to continue the process of applying Sherman Act principles to health care.

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[9] The legal profession has been the recent subject of antitrust reform. The changes necessitated by adherence to the antitrust laws do not appear to have inflicted serious damage on the profession or its clients. *See* Weller, *supra,* at 101.

The alternative to increased competition, partly secured through private and government enforcement of the antitrust laws, is probably total government control.[10] Few people consider this an appealing option. The choice, however, is not ours to make. We need only follow the mandate of the Sherman Act, which requires that competitive forces be allowed free rein. Only Congress can declare that health care is to be exempted from this mandate.

It might be argued that the challenged practice should not now be judged under a per se rule because courts have not yet had enough experience with this type of restraint to form a clear judgment about its competitive effects. *See Broadcast Music, Inc. v. Columbia Broadcasting System,*

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[10] *See generally* Enthoven. *Rx for Health Care Economics*, 59 Hosp. Prog. 44 (Oct. 1978); Havighurst, *Controlling Health Care Costs*, 1 J. Health Politics, Policy & Law 471 (1977); Havighurst & Hackbarth, *Private Cost Containment*, 300 N.Eng J. of Med. 1298 (1979); McClure, *On Broadening the Definition of and Removing Regulatory Barriers to a Competitive Health Care System*. 3 J. of Health Politics, Policy & Law 303 (1978).

Inc., supra.[11] This appears to be the thrust of the majority opinion. Such an argument is inappropriate here, because courts long ago determined that price tampering and maximum price-fixing among competitors lack significant competitive virtues and are therefore per se illegal. Even if this were the first judicial examination of this form of restraint, its anticompetitive vices are egregious and its procompetitive features nonexistent, so that this Court could declare it to be within the per se rules.[12]

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[11] In *Broadcast Music* the Supreme Court's major concern was the danger of too-quick characterization of conduct as price-fixing. Placing activity in the per se illegal price-fixing category essentially forecloses the issue of liability against the defendant. Therefore, care must be taken to ascertain that the conduct is indeed a traditional form of price-fixing, or a variant displaying similar anticompetitive aspects. The Court felt that defendant's behavior in *Broadcast Music* was not traditional price-fixing. 441 U.S. at 23 ("the blanket license cannot be wholly equated with a simple horizontal arrangement among competitors"). Defendant was already subject to antitrust decrees, *id.* at 10-16, and was seen as performing a middleman function, *id.* at 19-23. *See* Comment, 91 Harv.L.Rev. 488 (1977) (author's analysis apparently followed by Supreme Court).

Here we are examing conduct which is a customary form of price-fixing between competitors. 441 U.S. at 8 ("[A]greements among competitors to fix prices on their individual goods or services are among those concerted activities that the Court has held to be within the per se category."), and the deficiencies of "analysis by characterization" are not a problem. In my view, the fact that defendants' activity is conventional price-fixing makes this second area of inquiry unnecessary in this case. What is different here is not the challenged practice itself, but the industry in which it occurs. As I stated above at pages 6-8, that difference should not require abandonment of the per se rules.

[12] Civil liability under the Sherman Act may be predicated on a finding of either an unlawful purpose or an anticompetitive effect *McLain v. Real Estate Board of New Orleans, Inc.* 100 S.Ct. 502 (1980); *United States v. United States Gypsum Co.*, 438 U.S. 422, 436 n.13. (1978). Defendants' purpose here was to fix prices and to suppress competition. These are per se unlawful purposes. It may not be necessary to assess the actual competitive effects of the controverted behavior where the unlawful purpose is clear.

Three of the harms engendered by maximum fee-setting are elimination of the freedom of individual sellers and buyers to determine prices, the possibility that the "maximum" price is in reality being used to establish a price floor or price uniformity, and the use of a maximum price structure to inhibit entry of competing forms of health care delivery which might capture a significant market share and deflect income from traditional fee-for-service physicians. *See Albrecht v. Herald Co., supra,* at 152-53; L. Sullivan, *Handbook on the Law of Antitrust* § 78, p. 210-11 (1977); Havighurst, *supra,* at 377; Havighurst & Kissam, *supra,* at 55 68; Kallstrom, *supra,* at 650, 681-83. The record indicates that these harms were intended and have occurred in Arizona.

Defendants claimed that doctors were threatening to leave the Foundations if they could not increase fees. This is an admission that freedom of individual physicians to determine prices has been abolished. Similarly, third-party payors are unable to individually negotiate a lower fee. They are in a take-it-or-leave-it situation. Letters exchanged among doctors, specialty groups, and the defendants show that the fee schedules were not attempts to set a true ceiling price, but were designed to fix *the* fee which doctors would receive for performing a particular service. Finally, defendants have quite openly stated that their purpose is to protect fee-for-service medicine against competing forms of health care delivery. While the defendants may take steps to preserve traditional forms of business, they may not use restraints of trade to do so. It is not necessary to find predatory pricing to establish that defendants' activity had the goal of unlawfully suppressing competition.

The Foundations' plan is a cozy arrangement for both doctors and third-party payors and it diminishes their incentives to control costs. Assignment of benefits by patients covered under Foundation-approved insurance plans is apparently automatic. These claims are submitted for payment directly to the Foundations, eliminating third-party

review of bills. When doctors vote to raise the level of reimbursement, insurance companies are notified in advance so that they can increase premiums to cover their higher costs. The entire system is designed to avoid providing anyone with an incentive to control costs. In addition, this system of payment appears to have been created to tie up a large percentage of doctors and third-party payors by generating high revenues for them. This would discourage them from exploring alternate, more efficient forms of health care delivery and serves to insulate physicians' incomes from any competitive pressures. The only party who does not benefit is the consumer, who must pay ever greater amounts for medical care.

In light of the total absence of real incentives for any of the plan's participants to limit fees, it is misleading to suggest that a redeeming virtue of the maximum fee schedule is cost control. A detailed economic analysis is not always necessary to understand the purpose or effect of a particular activity. Logic and common sense tell us that it is unreasonable to expect that a combination of medical providers might willingly take measures which could reduce their income and which would require changes in the way they have traditionally conducted business.[13] This is especially true when the providers are doctors, who have a long history of resisting any challenge to fee-for-service medicine. Steps to check costs will have to be initiated by informed consumers with a wider competitive choice or, more likely, from third-party payors acting on behalf of consumers.[14] These intiatives will occur only if the power of physicians is decreased in relation to these parties. Allowing doctors to set fees certainly does not improve the situation. If the fee schedule established by the defendants were abolished, it could be expected that third-party payors would be able to negotiate with each physician or health care delivery unit individually, and might be able to insti-

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[13] *See* Havighurst & Kissam, *supra*, at 68.

[14] *See* Havighurst. *Controlling Health Care Costs*, *supra*, at 485.

tute genuine attempts to control costs. Doctors would be encouraged to find methods of doing business which would lower their fees and allow them to increase their share of third-party payor business. In short, a market with more competitive features could be brought into existence.

I do not agree with the majority's belief that the relevant inquiry is whether fees are higher or lower as a result of the defendants' conduct. I am confident that the fee schedule does have the effect of raising prices, and that in its absence consumers would ultimately obtain less expensive medical care. *See* Kallstrom, *supra*, at 650. The majority's emphasis on the level of fees, however, is a version of the "reasonableness of prices" justification for price-fixing. This defense has been repeatedly rejected. *National Society of Professional Engineers v. United States*, *supra*, at 689; *United States v. Trenton Potteries, Co.*, 273 U.S. 392, 397 (1927). Lower prices are not the sole measuring rod of competitive conditions, nor are they neccessarily the ultimate goal of the Sherman Act. That goal is the absence of restraints on market forces. *See Reiter v. Sonotone Corp.*, 99 S.Ct. 2326, 2332 (1979) ("essence of the antitrust laws is to ensure fair price competition in an *open* market" (emphasis added)); *National Society of Professional Engineers v. United States*, *supra*, at 692 (restraint illegal because it impedes the ordinary give and take of the marketplace); *Goldfarb v. State Bar of Virginia*, *supra*, at 785 ("Nor was it necessary for petitioners to prove that the fee schedule raised fees. Petitioners clearly proved that the fee schedule fixed fees and thus 'deprive[d] purchasers or consumers of the advantages which they derive from free competition' " (cites omitted)); *United States v. Socony-Vacuum Oil Co.*, 310 U.S. 150, 221 (1950) ("Any combination which tampers with price structures is engaged in an unlawful activity. Even though the members of the price-fixing group were in no position to control the market, to the extent that they raised, lowered, or stabilized prices they would be directly interfering with the free play of market forces.") Congress has decided that an open market

will result in public benefits, which may include lower prices. If these benefits do not result, Congress must rectify the problem, not the courts. Removal of the fee schedule here, however, clearly will be favorable to the general public.

The level or reasonableness of agreed-upon prices is also irrelevant because part of the danger in such agreements is the aggregation of competitors. Even though their initial price-tampering may seem benign, combinations of competitors possess considerable power which inevitably will be abused. *See United States v. Trenton Potteries, supra.* The Sherman Act requires that these consolidations of power be stopped in their infancy.

The fee schedule here presents serious competitive problems.[15] The only justification advanced on its behalf, cost control, is illusory and nonexistent. Based on an assessment of its competitive impact, this fee schedule should be subject to the per se standards traditionally applied to price-fixing.

Finally, even if the rule of reason is the correct standard by which to judge defendants' activities, a detailed economic analysis of the industry is not necessary. This agreement to fix fees is so plainly anticompetitive that it is an unreasonable restraint of trade on its face. *See National Society of Professional Engineers v. United States, Supra.*

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[15] The fee schedule also poses potential anticompetitive problems as a price information exchange. The schedule was widely disseminated and could be used by doctors who were not Foundation members and could be used to bill clients not covered by the third-party payors. In this way the schedule would have an even greater impact on prices. This price information sharing relates to the level of price and does not seem to have a market-perfecting function. As such it is a particularly dangerous. *See United States v. United States Gypsum Co., supra,* at 441 n.16; L. Sullivan, *supra.* at §§ 93-96; Posner, *Information & Antitrust,* 67 Geo.L.J. 1187 (1979).

Because no in-depth study is necessary and because it is obvious that the practice is illegal, Arizona's likelihood of success is extremely high. This contributes to the district court's error in refusing preliminary relief.

The majority counsels a cautious approach. The truly circumspect path would be to assume, until it is proven otherwise, that the per se rules, which have arisen from long experience with price tampering, are fully applicable to physician fee-setting. Because the district court used erroneous legal premises and abused its discretion in weighing the preliminary injunction factors, this Court should either grant preliminary relief to plaintiff or order the district court to reconsider its decision to deny a preliminary injunction.

Filed—APR 28 1980
Richard H. Deane, Clerk
U.S. Court of Appeals

UNITED STATES COURT OF APPEALS
FOR THE NINTH CIRCUIT

STATE OF ARIZONA,
Plaintiff-Appellant,
v.
MARICOPA COUNTY MEDICAL SOCIETY, an Arizona non-profit corporation; MARICOPA FOUNDATION FOR MEDICAL CARE, an Arizona non-profit corporation; PIMA COUNTY MEDICAL SOCIETY, an Arizona non-profit corporation; and PIMA FOUNDATION FOR MEDICAL CARE, an Arizona non-profit coporation,
Defendants-Appellees.

No. 79-3427

STATE OF ARIZONA
Plaintiff-Appellant,
v.
MARICOPA COUNTY MEDICAL SOCIETY, an Arizona non-profit corporation; MARICOPA FOUNDATION FOR MEDICAL CARE, an Arizona non-profit corporation; and PIMA FOUNDATION FOR MEDICAL CARE, an Arizona non-profit corporation,
Defendants-Appellees.

No. 79-3612

ORDER

Before: SNEED and KENNEDY, Circuit Judges, and LARSON,* District Judge

*Honorable Earl R. Larson, Senior United States District Judge for the District of Minnesota, sitting by designation

The opinion filed in this case on March 20, 1980 is corrected as follows: Pages 11 and 12 are replaced by the attached pages and Footnote No. 7 is added.

Expansionary Answer to the Prophylactic Riddle of Section Two, 72 Mich. L. Rev. 373, 435-40 (1974); Williamson, *Predatory Pricing: A Strategic and Welfare Analysis*, 87 Yale L. J. 284 (1977). As these authorities illustrate, however, there is nothing like agreement concerning the signs by which predation is identifiable.[6] Without deciding what the proper identifying signs may be, we are confident that none is revealed by this record. Moreover, the evil of predatory pricing is that it makes possible an ultimate capture of monopoly profits. Were prices maintained at the predatory level indefinitely the case against predatory pricing would more resemble that against suicide than that against monopolies.

The question whether the practice of which the appellant complains is sheltered from antitrust challenge by the McCarran-Ferguson Act, 15 U.S.C. § 1012, is not before us.[7] For the purposes of this appeal we assume that the practice of which the appellant complains was not "the

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[7] The district court reasoned that since

> the agreements between physicians participating in the foundation-approved plans and the insurers underwriting the plans . . . spread no risk peculiar to the business of insurance, the McCarran-Ferguson Act exemption does not apply to exempt the defendants' conduct from possible antitrust liability . . . .

Arizona v. Maricopa County Medical Society, No. CIV-78-800 PHX WPC (D. Ariz. June 11, 1979) (memorandum and order), Designated Record at 22-24. The parties before us have not attacked that holding. Recently, however, the Fourth Circuit decided that a chiropractors' association performing peer review and fee supervision on behalf of health insurers was within the exemption. Bartholomew v. Virginia Chiropractors Ass'n, Nos. 78-1734, 78-1735, 78-1736 (4th Cir. Nov. 20, 1979). The *Bartholomew* court explained that "the procurement of drugs," with which Group Life and Insurance Co. v. Royal Drug Co., 440 U.S. 205 (1979) dealt, was "admittedly an act only thinly tangential to the business of insurance," whereas the chiropractors' association played a part in insurance as "a single, composite business." *Bartholomew*, *supra*, at 12. We express no opinion regarding the validity of this distinction.

business of insurance." No more was held with respect to the practice involved in *Royal Drug*. The issue whether that practice violated the antitrust laws expressly was not decided. Here we confront precisely that type of issue and merely hold that the challenged practice is not a per se violation.

We conclude by observing that we draw comfort from the Supreme Court's reiteration in *National Society of Professional Engineers, supra*, 435 U.S. at 696 n.22, of its statement in *Goldfarb v. Virginia State Bar*, 421 U.S. 773 (1975) that marketing restraints that regulate professional competition may pass muster under the Rule of Reason even though similar restraints on ordinary business competition would not. We believe this recognizes that a restraint may serve the public, the transcendent end of all professions, even though its presence in a purely commercial setting would violate the antitrust law. *See Professional Engineers, supra*, 435 at 696 & n.22; *Boddicker v. Arizona State Dental Association*, 549 F.2d 626 (9th Cir. 1977). There is sufficient probability of the challenged practice in this case being sheltered by this principle to justify our refusal to brand it as a per se violation.

Affirmed.

Filed—NOV 19 1979
Richard H. Deane
U.S. Court of Appeals

UNITED STATES COURT OF APPEALS
FOR THE NINTH CIRCUIT

STATE OF ARIZONA,
Plaintiff-Appellant,
v.
MARICOPA COUNTY MEDICAL SOCIETY, an Arizona non-profit corporation; MARICOPA FOUNDATION FOR MEDICAL CARE, an Arizona non-profit corporation; PIMA COUNTY MEDICAL SOCIETY, an Arizona non-profit corporation; and PIMA FOUNDATION FOR MEDICAL CARE, an Arizona non-profit corporation,
Defendants-Appellees.

No. 79-3427

STATE OF ARIZONA,
Plaintiff-Appellant,
v.
MARICOPA COUNTY MEDICAL SOCIETY, an Arizona non-profit corporation; MARICOPA FOUNDATION FOR MEDICAL CARE, an Arizona non-profit corporation; and PIMA FOUNDATION FOR MEDICAL CARE, an Arizona non-profit corporation,
Defendants-Appellees.

No. 79-3612

ORDER

Appeal from the United States District Court
for the District of Arizona

Before: SNEED and KENNEDY, Circuit Judges, and LARSON,* District Judge.

The stay granted in this court's order of August 31, 1979, No. 79-3427, is hereby dissolved, and the orders of the lower court denying preliminary injunctions in these consolidated cases are affirmed. With respect to the interlocutory appeal in No. 79-3612, we conclude that on the present state of the record the defendants' conduct should not be considered a per se violation of the Sherman Act, 15 U.S.C. § 1.

An opinion by the court will be filed in due course.

LARSON, District Judge, Dissenting:

I respectfully dissent.

National Society of Professional Engineers v. United States, 435 U.S. 679 (1978) and *Goldfarb v. Virginia State Bar*, 421 U.S. 773 (1975) established that professional price-fixing is subject to a per se analysis under the Sherman Act. I see nothing in the nature of the medical profession or this particular arrangement which would dictate application of a lesser standard. Therefore, I dissent from the lifting of the stay.

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*Honorable Earl R. Larson, Senior United States District Judge for the District of Minnesota, sitting by designation.

Filed—JUN 5 1979
W.J. Furstenau, Clerk
U.S. District Court
For The District of Arizona

IN THE UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF ARIZONA

STATE OF ARIZONA, Plaintiff, vs. MARICOPA COUNTY MEDICAL SOCIETY, an Arizona non-profit corporation; MARICOPA FOUNDATION FOR MEDICAL CARE, an Arizona non-profit corporation; PIMA COUNTY MEDICAL SOCIETY, an Arizona non-profit corporation; and PIMA FOUNDATION FOR MEDICAL CARE, an Arizona non-profit corporation, Defendants.	No. CIV-78-800 PHX WPC MEMORANDUM AND ORDER

The State of Arizona has charged the Maricopa County Medical Society, Maricopa Foundation for Medical Care, Pima County Medical Society and Pima Foundation for Medical Care with violations of section 1 of the Sherman Act, 15 U.S.C. § 1, and the Arizona Uniform State Antitrust Act, A.R.S. §§ 44-1401 *et seq.* Arizona, in particular, asserts that the defendants have combined and conspired with others to fix, raise and maintain prices charged by doctors, and to establish and maintain systems for determining prices charged by doctors which include establishing and maintaining relative value schedules and conversion factors. Maricopa Foundation for Medical Care and Pima Foundation for Medical Care are associations of doctors. The

foundations approve and administer insurance plans underwritten by private insurers. The foundation-approved insurance plans allegedly offer an alternative to health maintenance organizations.

It is undisputed that the foundations set the maximum amount to be paid physicians who agree to provide services to patients who are enrolled in insurance plans approved by the foundations. It is further undisputed that the doctors who agree to participate in the foundation-approved plans are free to set the prices they charge their patients.

Maricopa Foundation has moved to dismiss the complaint for failure to state a claim, arguing that any conduct that would otherwise constitute an antitrust violation is exempt from antitrust liability by virtue of the McCarran-Ferguson Act, 15 U.S.C. § 1012. Arizona has moved for partial summary judgment determinations as to subject-matter jurisdiction and liability.

The McCarran-Ferguson Act exempts from the Sherman Act that conduct which constitutes the business of insurance and which is regulated by state law. *See* 15 U.S.C. § 1011 *et seq.* The Supreme Court has recently narrowly construed the statutory phrase "the business of insurance" to exclude an arrangement where insurance companies agreed with pharmacists on the maximum amount that the pharmacists would be reimbursed for prescriptions they filled. *See Group Life & Health Ins. Co. v. Royal Drug Co., Inc.*, 99 S.Ct. 1067 (1979). The Court held that to be within the McCarran-Ferguson Act exemption, the conduct must involve the underwriting or spreading of a risk. *Id.* at 1073-74.

The defendants have argued that the agreements between physicians participating in the foundation-approved plans and the insurers underwriting the plans spread the risk that the cost of providing services to a foundation policyholder will be more than the maximum amount a participating physician would receive. Yet every contract

for the sale of goods or services in the future at a specified price protects the parties against future fluctuations in the market price. Such an underwriting of a risk is not peculiar to the "business of insurance."

The risk that is peculiar to the "business of insurance" is the risk that policyholders cannot afford the services of a physician when needed. The participating insurance companies underwrite or assume this risk in return for the payment of premiums. The effect is that the risk is spread among all policyholders such that the magnitude of the risk to the individual policyholder is reduced. Merely because an insurance company acts to reduce the risk that it has underwritten does not directly further underwrite or spread the risk that the policyholders sought to insure against. The obligations that the participating insurance companies have incurred remains constant. How they go about satisfying that obligation does not involve the business of insurance since a reduction in liability and thus the risk they have assumed does not change the risk against which the policyholder obtained insurance. The Supreme Court in *Royal Drug* wrote in relevant part:

> The fallacy of the petitioners' position is that they confuse the obligations of Blue Shield under its insurance policies, which insure against the risk that policyholders will be unable to pay for prescription drugs during the period of coverage, and the agreements between Blue Shield and the participating pharmacies, which serve only to minimize the costs Blue Shield incurs in fulfilling its underwriting obligations . . . .
>
> The . . . Agreements . . . do not involve any underwriting or spreading of risk, but are merely arrangements for the purchase of goods and services by Blue Shield . . . . Such cost savings arrangements may well be sound business practice, and may well inure ultimately to the benefit of policyholders in the form of lower premiums, but they are not the "business of insurance."

Group Life & Health Ins. Co. v. Royal Drug Co., Inc., *supra*, 99 S.Ct. at 1074-75. Because the agreements between the defendants and the insurance companies underwrite or spread no risk peculiar to the business of insurance, the McCarran-Ferguson Act exemption does not apply to exempt the defendants' conduct from possible antitrust liability and the defendants' motion to dismiss is denied.

Subject-matter jurisdiction under federal antitrust law is co-extensive with the Congressional power under the Constitution to regulate interstate commerce. *United States v. South-Eastern Underwriter's Ass'n*, 322 U.S. 533, 558-59, 64 S.Ct. 1162, 88 L.Ed. 1440 (1944). Whether the Court has subject-matter jurisdiction over the complaint depends on whether the acts allegedly restrained by the acts complained of occur in the flow of commerce, or whether those acts, although local, substantially affect interstate commerce. *See Hospital Building Co. v. Trustees of Rex Hospital*, 425 U.S. 738, 743, 96 S.Ct. 1848, 1851-52, 48 L.Ed. 2d 338 (1976). The alleged price-fixing of services, goods and products sold by participating physicians to foundation policyholders presumably restrains the sale of the services, goods and products sold by the participating physicians. The sales are not interstate transactions, since the sales occur wholly within the state. No services cross state lines and any goods or products that cross state lines are no longer in the flow of interstate commerce when sold at retail. *See* P. Areeda & D. Turner, Antitrust Law ¶¶ 31-32 (1973). That the doctors are paid with funds that cross state lines according to contracts that cross state lines or prescribe drugs that cross state lines does not make the services or products they sell something that is in the flow of interstate commerce.

However, it cannot be disputed that health insurance is an interstate business where premiums and payments on claims cross state lines. The alleged price-fixing affects the sale of services by physicians and the sale of services rendered by physicians directly affects the premiums and payments that cross state lines. It is undisputed that the

amount of premiums and payments on claims that annually cross state lines exceeds the amounts involved in *Hospital Building Co. v. Trustees of Rex Hospital, supra.* Thus, the criteria of *Goldfarb v. Virginia State Bar,* 421 U.S. 773, 95 S.Ct. 2004, 44 L.Ed.2d 575 (1975), that there must be both substantial interstate commerce and a necessary or integral relationship between the allegedly restrained activity and the interstate commerce are satisfied, thereby establishing subject-matter jurisdiction. *See Ohio v. Ohio Medical Indemnity, Inc.,* 1976-2 Trade Cases (CCH) ¶ 61,128 (S.D. Ohio 1976). *See also De Voto v. Pacific Fidelity Life Ins. Co.,* 516 F.2d 1, 5 (9th Cir.), *cert. denied,* 423 U.S. 894 ("Interstate insurance transactions fall within the definition of interstate commerce as that term is applied pursuant to federal antitrust regulation, and '[i]f it is interstate commerce that feels the pinch, it does not matter how local the operation which applies the squeeze.' ").

Although the question of subject-matter jurisdiction is normally addressed by a motion to dismiss and a finding of lack of subject-matter jurisdiction requires dismissal, finding jurisdiction does not preclude entering partial summary judgment on that issue. *See Page v. Work,* 290 F.2d 323 (9th Cir.), *cert. denied,* 368 U.S. 875 (1961). Because the Court finds it has subject-matter jurisdiction over the plaintiff's antitrust claim, the motion by the plaintiff for partial summary judgment on the issue of subject-matter jurisdiction is granted.

Based on the affidavit of Anthony D. Mitten, it is clear that the defendant Maricopa Foundation for Medical Care (and presumably the Pima Foundation for Medical Care as well) sets the maximum fees paid by the insurance companies underwriting foundation-approved plans to the physicians associated with the foundation for services performed by them on patients covered by the foundation-endorsed plans. That the participating physicians are free to charge whatever price they wish is of no consequence as

they have agreed in advance to accept in full satisfaction the amount determined by the medical foundation when the amount they charge exceeds that established by the foundation.

Price-fixing has for some time been viewed as per se unlawful. *See United States v. Socony-Vacuum Oil Co.*, 310 U.S. 150, 60 S.Ct. 811, 84 L.Ed. 1129 (1940). Under the per se approach, there is no inquiry into whether the challenged practice actually has an anticompetitive effect. The per se rule has been applied to fixing maximum prices as well as minimum prices. *Kiefer-Stewart Co. v. Joseph E. Seagram & Sons, Inc.*, 340 U.S. 211, 71 S.Ct. 259, 95 L.Ed. 219 (1951). No evidence has been submitted that the insurance companies individually determined the maximum prices to be paid and that the physicians individually agreed to those terms which presumably would preclude finding any antitrust violation even under a per se analysis. *See* Department of Justice Clearance Letter, January 15, 1968, Appendix E, Amicus Curiae Brief of the Blue Shield Association, Group Life and Health Ins. Co. v. Royal Drug Co., Inc. (1977).

The defendants urge that the challenged practices should be analyzed under the "Rule of Reason" approach. Under the Rule of Reason approach, an inquiry is made to determine whether the purpose or effect of the practice in question would significantly hamper competition. *See* Sullivan, Handbook on Antitrust §§ 68-72 (1977). Although the per se approach avoids inquiry into difficult economic issues, a recent antitrust trend appears to be emerging where the Rule of Reason is the preferred method of determining whether a particular practice is in violation of the antitrust law. *See Continental T.V., Inc. v. GTE Sylvania Inc.*, 433 U.S. 36, 97 S.Ct. 2549, 53 L.Ed.2D 568 (1977) (vertical restraints, formerly per se violations, are now to be analyzed under the Rule of Reason approach); *General Glass Co., Inc. v. Globe Glass and Trim Co.*, [1978-2] Trade Cases 75,487, 75,490 (N.D. I11. 1978) ("That all price-fixing is *per se* violative of antitrust laws is a concept that is presently

being revised in favor of a 'rule of reason' approach.") *See also* Handler, "Changing Trends in Antitrust Doctrines: An Unprecedented Supreme Court Term—1977," 77 *Columb. L. Rev.* 979, 989 (1977):

> *Sylvania* marks not only the reinstatement of the rule of reason, but also a reawakening to the requirements of business .... It is clear ... that the courts will no longer have to wear per se blinders in passing upon the many business restrictions which do have "redeeming virtues" and may actually help to promote competition."

Additionally, the two Supreme Court cases invalidating maximum price-fixing, *Kiefer-Stewart Co. v. Joseph E. Seagram & Sons, Inc., supra*, and *Albrecht v. Herald Co.*, 390 U.S. 145, 88 S.Ct. 869, 19 L.Ed.2d 998 (1968), need not be read as establishing a per se rule. According to one commentator,

> [m]ost writers have determined that *Kiefer-Stewart* and *Albrecht* should not be read to denounce maximum RPM [resale price maintenance] under the per se rule. Unlike normal per se cases, these decisions were not the culmination of a long series of rulings establishing that the challenged practice can rarely, if ever, be justified and that the usual evidentiary inquiry into purpose, power and effect would be wasteful. Nor did these decisions discuss the possible benefits and detriments to efficiency and competition posed by the restraint under attack, so as to conclude that virtually *no* defense would be successful, as have most per se cases. It is plain, moreover, that the results of *Kiefer-Stewart* and *Albrecht* can be explained by rule of reason analysis. Consequently, there is no need to read them as per se holdings condemning maximum RPM.

Kallstrom, "Health Care Cost Control by Third Party Payors: Fee Schedules and the Sherman Act," 1978 *Duke L.J.* 645, 666-68.

Another consideration in determining whether to apply the Rule of Reason approach is that a profession is involved here.

> It has long been recognized that the professions differ fundamentally from ordinary commercial businesses and, consequently, merit more liberal treatment under the antitrust laws. Courts have generally assumed that the professions exist for reasons in addition to the profit motive. The essence of the concept of "profession" is the power to self-regulate and to promote standards of practice that benefit the public at large as well as the individual practitioners.

Comment, "The Professions and Noncommercial Purposes: Applicability of Per Se Rules Under the Sherman Act," 11 *U. Mich. J. L. Reform* 387, 394 (1978). *See also* Note, "Application of the Antitrust Laws to Anticompetitive Activities by Physicians," 30 *Rutgers L. Rev.* 991, 1019 (1977) ("Recognizing that the per se rules were fashioned in a wholly commercial context, courts traditionally have not included highly regulated but traditionally noncommercial industries within the scope of those rules."). The Supreme Court has recognized the distinction between a purely commercial business and a profession, commenting in *Goldfarb, supra:*

> The fact that a restraint operates upon a profession as distinguished from a business is, of course, relevant in determining whether that particular restraint violates the Sherman Act. It would be unrealistic to view the practice of professions as interchangeable with other business activities and automatically apply to the professions antitrust concepts which originated in other areas. The public service aspect, and other features of the professions, may require that a particular practice, which could be properly viewed as a violation of the Sherman Act in another context, be treated differently.

421 U.S. at 788 N.17, 95 S.Ct. at 2013.

In *National Society of Professional Engineers v. United States*, 435 U.S. 679, 98 S.Ct. 1355 (1978), the Supreme Court further indicated that conduct of professions allegedly in violation of the antitrust laws may be subjected to a Rule of Reason analysis. Although the Court concluded that no elaborate industry analysis was necessary to find that the challenged conduct was in violation of the antitrust laws, the Court did discuss at length the Rule of Reason, stating that "certain practices by members of a learned profession might survive scrutiny under the Rule of Reason even though they would be viewed as a violation of the Sherman Act in another context." *Id.* 435 U.S. at _____, 98 S.Ct. at 1362. Nowhere did the Court state that the defendant could assert no defense that the conduct challenged was reasonable, only that the particular defense of protecting against inferior work was legally insufficient.

The Ninth Circuit, when confronted with an alleged tying arrangement, normally a per se violation, by a profession, wrote:

> [T]he Supreme Court does not require that the practices challenged here be treated the same as would be proper if dentistry were merely a commercial enterprise.
>
> As we interpret the Court, to survive a Sherman Act challenge a particular practice, rule, or regulation of a profession, whether rooted in tradition or the pronouncements of its organizations, must serve the purpose for which the profession exists, *viz.* to serve the public. That is, it must contribute directly to improving service to the public. Those which only suppress competition between practitioners will fail to survive the challenge. This interpretation permits a harmonization of the ends that both the professions and the Sherman Act serve.

Boddicker v. Arizona State Dental Ass'n, 549 F.2d 626, 632 (9th Cir.), *cert. denied*, 434 U.S. 825 (1977). Reversing the dismissal of the case and remanding the case for further proceedings to permit the defendants to show how the chal-

lenged conduct promoted the improvement of professional services to the public indicates that the Rule of Reason is to be applied when analyzing practices of professions alleged to be in violation of the antitrust laws. *See also Mackey v. National Football League*, 543 F.2d 606 (8th Cir. 1976) (the challenged rule characterized as a refusal to deal and a group boycott was held to be more appropriately tested under the Rule of Reason than to be declared per se violative of the Sherman Act). It has been aptly observed that

> [a]lthough no firm consensus exists as to the social and economic goals of the Sherman Act, it is at least clear that per se rules arose out of the courts' experience with commercial activities whose purposes and anticompetitive effects differ significantly from those of the professions. The mechanical application of per se rules of illegality in the professional setting contradicts the basic rule that only unreasonable restraints are condemned by the Sherman Act .... [W]ithout the benefit of long experience with the professions in the antitrust arena, the conclusions garnered from traditional commercial practices should not be carried over unthinkingly to professional practices.

Comment, *supra*, 11 *U. Mich. J. L. Reform*, at 415.

In light of the above, the Court concludes that the Rule of Reason approach should be used in analyzing the challenged conduct in the instant case. Choosing the Rule of Reason approach precludes granting the plaintiff's motion for partial summary judgment on the issue of liability because there is insufficient evidence as to the [purpose and effect of the allegedly unlawful practices and the power of the defendants.] As a consequence of adopting the Rule of Reason, the December 18, 1978, order of the Court denying defendant Maricopa Foundation's motion for an order compelling discovery of certain information and documents such as the relative value schedules, unit conversion factors or fee schedules used by the plaintiff is vacated. Under the Rule of Reason approach, such information is relevant in

determining the purpose and effect of the challenged conduct. Therefore,

IT IS ORDERED:

1. The defendants' motion to dismiss based on the McCarran-Ferguson Act exemption is denied.

2. The plaintiff's motion for partial summary judgment on the issue of subject-matter jurisdiction is granted.

3. The plaintiff's motion for partial summary judgment on the issue of liability is denied with leave to file a similar motion based on additional evidence if appropriate.

4. The December 18, 1978, order of the Court denying defendant Maricopa Foundation's motion for an order compelling discovery is vacated.

DATED June 5, 1979.

United States District Judge

CIVIL MINUTES OF THE UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF ARIZONA

PLACE: Phx.

☐ HON. WALTER E. CRAIG ☐ HON. CARL A. MUECKE
☑ HON. WILLIAM P. COPPLE

☐ HON. _____

Deputy Clerk	Court Reporter
___ Vera Whiteside	___ Lloyd Weyenberg
___ Rita Zambonini	___ Gloria Frandle
✓ Becky Daudet	✓ Thomas Stalcup
___ Dorothy Kennedy	
___ _____	___ _____

CIV- 78-800 Phx.

State of Arizona (Plaintiff) vs. Maricopa County Medical Society, et al (Defendant)

DOCKET NUMBER	MATTER ON FOR HEARING
(105)	Pltf's motion for summary judg. and permanent injunction and motion for reconsideration of memo. and order of June 5, 1979

APPEARANCES

Patricia Metzger pres. for Atty General
Philip Berelson and Ken Nyman pres. for Defts.

MINUTES

Order motion for reconsideration denied
Motion for summary judg. Denied
and interlocutory appeal granted and pltf. to submit certificate

___U/___ ___N/___ ___ Vacated Con't to: _____

DOCKETED BY:

DATE: 8-6-79 /s/
Deputy Clerk

Filed—AUG 8 1979
W.J. Furstenau, Clerk
U.S. District Court
For The District of Arizona

IN THE UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF ARIZONA

STATE OF ARIZONA, Plaintiff, vs. MARICOPA COUNTY MEDICAL SOCIETY, an Arizona non-profit corporation; MARICOPA FOUNDATION FOR MEDICAL CARE, an Arizona non-profit corporation; PIMA COUNTY MEDICAL SOCIETY, an Arizona non-profit corporation; and PIMA FOUNDATION FOR MEDICAL CARE, an Arizona non-profit corporation, Defendants.	No. CIV-78-800 PHX WPC CERTIFICATE AND ORDER

IT IS HEREBY ORDERED that:

The Order of this Court entered June 5, 1979 is amended by addition of the following: This Court's determination that the Rule of Reason approach should be used in analyzing the challenged conduct in the instant case to determine whether a violation of Section 1 of the Sherman Act has occurred involves a question of law as to which there is substantial ground for difference of opinion and an immediate appeal from the Order denying plaintiff's motion for partial summary judgment on the issue of liability may materially

advance the ultimate determination of the litigation. Therefore, the foregoing Order and determination of the Court is certified for interlocutory appeal pursuant to 28 U.S.C. § 1292(b).

DATED this 8 day of August, 1979.

Judge of the United States District Court

Filed—MAY 30 1980
Richard H. Deane, Clerk
U.S. Court of Appeals

UNITED STATES COURT OF APPEALS
FOR THE NINTH CIRCUIT

STATE OF ARIZONA,
Plaintiff-Appellant,
v.
MARICOPA COUNTY MEDICAL SOCIETY, an Arizona non-profit corporation; MARICOPA FOUNDATION FOR MEDICAL CARE, an Arizona non-profit corporation; PIMA COUNTY MEDICAL SOCIETY, an Arizona non-profit corporation; and PIMA FOUNDATION FOR MEDICAL CARE, an Arizona non-profit coporation,
Defendants-Appellees.

No. 79-3427

STATE OF ARIZONA
Plaintiff-Appellant,
v.
MARICOPA COUNTY MEDICAL SOCIETY, an Arizona non-profit corporation; MARICOPA FOUNDATION FOR MEDICAL CARE, an Arizona non-profit corporation; and PIMA FOUNDATION FOR MEDICAL CARE, an Arizona non-profit corporation,
Defendants-Appellees.

No. 79-3612

ORDER

Before: SNEED and KENNEDY, Circuit Judges, and LARSON,* District Judge

*Honorable Earl R. Larson, Senior United States District Judge for the District of Minnesota, sitting by designation.

Plaintiff-Appellant's Petition for Rehearing and Suggestion of Appropriateness of Rehearing In Banc is ordered filed.

Filed—JUN 18 1980
Richard H. Deane, Clerk
U.S. Court of Appeals

UNITED STATES COURT OF APPEALS
FOR THE NINTH CIRCUIT

STATE OF ARIZONA,
Plaintiff-Appellant,
v.
MARICOPA COUNTY MEDICAL SOCIETY, an Arizona non-profit corporation; MARICOPA FOUNDATION FOR MEDICAL CARE, an Arizona non-profit corporation; PIMA COUNTY MEDICAL SOCIETY, an Arizona non-profit corporation; and PIMA FOUNDATION FOR MEDICAL CARE, an Arizona non-profit coporation,
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Defendants-Appellees.

No. 79-3612

ORDER

Before: SNEED and KENNEDY, Circuit Judges, and LARSON,* District Judge

*Honorable Earl R. Larson, Senior United States District Judge for the District of Minnesota, sitting by designation.

The panel as constituted in the above case has voted to deny the petition for rehearing and to reject the suggestion for rehearing en banc.

The full court has been advised of the suggestion for en banc rehearing, and no judge of the court has requested a vote on the suggestion for rehearing en banc. Fed. R. App. P. 35(b).

The petition for rehearing is denied and the suggestion for a rehearing en banc is rejected.

Office-Supreme Court, U.S.
FILED
JUN 15 1981
ALEXANDER L. STEVAS,
CLERK

No. 80-419

IN THE

Supreme Court of the United States

OCTOBER TERM, 1980

STATE OF ARIZONA,
Petitioner,

vs.

MARICOPA COUNTY MEDICAL SOCIETY,
MARICOPA FOUNDATION FOR MEDICAL CARE, and
Pima Foundation For Medical Care,
Respondents.

ON WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE NINTH CIRCUIT

JOINT APPENDIX

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PETITION FOR CERTIORARI FILED SEPTEMBER 16, 1980
CERTIORARI GRANTED MARCH 9, 1981

No. 80-419

IN THE

Supreme Court of the United States

OCTOBER TERM, 1980

STATE OF ARIZONA,
Petitioner,

vs.

MARICOPA COUNTY MEDICAL SOCIETY,
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Pima Foundation For Medical Care,
Respondents.

ON WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE NINTH CIRCUIT

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November 15, 1978—Answer of Defendant Pima Foundation for Medical Care

November 17, 1978—Judgment (Pima County Medical Society)

November 20, 1978—Plaintiff's Motion for Partial Summary Judgment on the Issue of Liability and Notice of Hearing

November 20, 1978—Memorandum in Support of Plaintiff's Motion for Partial Summary Judgment on the Issue of Liability

December 7, 1978—Defendant Pima Foundation's Response to Plaintiff's Motion for Partial Summary Judgment on the Issue of Liability

December 11, 1978—Response of Defendant Maricopa County Medical Society to Plaintiff's Motion for Partial Summary Judgment on the Issue of Liability

December 11, 1978—Defendant Maricopa County Medical Society's Response to Plaintiff's Statement of Undisputed Material Facts on its Motion for Partial Summary Judgment on the Issue of Liability

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July 6, 1979—Plaintiff's Motion for Reconsideration of Memorandum and Order of June 5, 1979, or, Alternatively, Motion for Certification for Interlocutory Appeal Pursuant to 28 U.S.C. §1292(b) of Memorandum and Order

July 17, 1979—Notice of Appeal—from the Order granting defendants' motion to vacate the April 30, 1979 temporary restraining order

August 6, 1979—Minute Entry: Motion for Reconsideration denied; Motion for Summary Judgment [under rule of reason] denied; interlocutory appeal granted

August 8, 1979—Certificate and Order that the Order entered June 5, 1979 is amended and is certified for interlocutory appeal

August 8, 1979—Order Staying Proceedings pending the final determination of the Court of Appeals with respect to the interlocutory appeal

November 19, 1979—Order of the Court of Appeals for the Ninth Circuit

March 20, 1980—Opinion of the United States Court of Appeals for the Ninth Circuit

April 28, 1980—Order of the United States Court of Appeals for the Ninth Circuit [Modifying the Opinion]

June 18, 1980—Order of the Court of Appeals for the Ninth Circuit [Denying Petition for Rehearing and Suggestion of Appropriateness of Rehearing In Banc]

Filed - OCT 17, 1978
W. J. Furstenau, Clerk
U. S. District Court
For The District of Arizona

IN THE UNITED STATES DISTRICT COURT FOR THE DISTRICT OF ARIZONA

STATE OF ARIZONA, *Plaintiff,* vs. MARICOPA COUNTY MEDICAL SOCIETY, an Arizona non-profit corporation; MARICOPA FOUNDATION FOR MEDICAL CARE, an Arizona non-profit corporation; PIMA COUNTY MEDICAL SOCIETY, an Arizona non-profit corporation; and PIMA FOUNDATION FOR MEDICAL CARE, an Arizona non-profit corporation, *Defendants.*	NO. CIV. 78-800 PHX WPC ANTITRUST COMPLAINT AND DEMAND FOR JURY TRIAL

The STATE OF ARIZONA, on its own behalf and as *parens patriae* on behalf of the citizens of the State of Arizona, brings this action for injunctive and declaratory relief and alleges as follows:

COUNT ONE

I

JURISDICTION AND VENUE

1. Count One of this Complaint is brought and the jurisdiction of this Court is invoked under 28 U.S.C. §§ 1331 and 1337 and Section 16 of the Clayton Act, 15 U.S.C. § 26, for injunctive and declaratory relief against the defendants' continuing violations of Section 1 of the Sherman Act, 15 U.S.C. § 1.

2. The claims for relief set forth in Counts One and Two of this Complaint are derived from a common nucleus of operative facts involving substantially identical issues of fact and law. The entire action constitutes a single case which ordinarily would be tried in one judicial proceeding. For the interests of judicial economy, covenience and fairness and in order to avoid unnecessary duplication and multiplicity of actions, this Court's jurisdiction over Count Two is pendent to this Court's jurisdiction over Count One.

3. Venue as to each defendant is laid in this judicial district pursuant to 28 U.S.C. §§ 1391(b) and (c) and Section 12 of the Clayton Act, 15 U.S.C. § 22. Each of the defendants is incorporated, maintains an office, and transacts business within the District of Arizona. The claims for relief alleged herein arose within the District of Arizona. Each of the defendants, together with its members, is within the jurisdiction of this Court.

4. The interstate trade and commerce described herein is conducted into, within and from the District of Arizona. The acts complained of herein are within the flow of interstate trade and commerce and have a direct and substantial effect on that trade and commerce.

II
DEFINITIONS

5. As used herein:

(a) "Doctor" means a Doctor of Medicine (M.D.), Doctor of Osteopathy (D.O.) or Doctor of Podiatry (D.P.M.) who is duly licensed to practice in the State of Arizona.

(b) "Doctor's service" means any medical, surgical or other health care procedure or service performed by a doctor or person working under the supervision of a doctor in return for a price based on that procedure or service.

(c) "Relative value schedule" means a list or compilation of doctor's services which sets comparative unit values for those services.

(d) "Unit conversion factor" means a number or dollar figure used to multiply the unit value for any doctor's service into a dollar figure payable for that service.

(e) "Health insurance" means a system of protection in which periodic payments (premiums) are made to an insurer in return for that insurer's underwriting the risk of certain medical costs that may be incurred by the policyholder.

(f) "Foundation Plan" means a health insurance plan endorsed by Defendant Maricopa Foundation for Medical Care or Defendant Pima Foundation for Medical Care.

(g) "Foundation policyholder" means any person whose medical expenses are insured in whole or part through a Foundation Plan, whether or not that person pays the premium for such insurance.

(h) "Foundation member" means any participating or cooperating member of Defendant Maricopa Foundation for Medical Care or Defendant Pima Foundation for Medical Care.

(i) "Foundation subscriber" means any individual, group, employer or governmental entity that paid all or part of the premium for any Foundation plan.

III
PLAINTIFF

6. Plaintiff, the State of Arizona, brings this action on its own behalf and as *parens patriae* on behalf of the citizens of the State of Arizona.

7. The State of Arizona and its citizens purchase substantial amounts of doctors' services and health insurance and have been and continue to be injured by the violations of the antitrust laws alleged herein. In 1977 the State of Arizona alone paid $7,615,536 for health insurance premiums. The State of Arizona has also paid substantial sums directly to doctors for services, goods and equipment.

IV
DEFENDANTS

8. Each of the corporations named below is made a defendant herein.

(a) The Maricopa County Medical Society (hereinafter the "Maricopa Society") is an Arizona non-profit corporation with its principal place of business in Phoenix, Arizona. The Maricopa Society is an association of licensed practitioners of medicine or surgery in Maricopa County, Arizona.

(b) The Maricopa Foundation for Medical Care (hereinafter the "Maricopa Foundation") is an Arizona non-profit corporation with its principal place of business in Phoenix, Arizona. The Maricopa Foundation is an association of doctors having four classes of members. Its "administrative members" are the members of the Board of Directors of the Maricopa Society. Its "participating members" are doctors who are qualified to be or are active members of the Maricopa Society or another county medical society in the State of Arizona or the Arizona Osteopathic Society. Its "cooperating members" are members of the Arizona Podiatry Society or the Arizona Society of Oral Surgeons. Its "PSRO members" are providers of doctor's services to Federal Medicare patients. The Maricopa Foundation is controlled by the Maricopa Society. The Executive Director of the Maricopa Society is also the Executive Director of the Maricopa Foundation. Over 70 percent of the doctors practicing in Maricopa County are participating or cooperating members of the Maricopa Foundation having a right to vote on the adoption of uniform, average or median fee schedules.

(c) The Pima County Medical Society (hereinafter the "Pima Society") is an Arizona non-profit corporation with its principal place of business in Tucson, Arizona. The Pima Society is an association of licensed practitioners of medicine or surgery in Pima County, Arizona.

(d) The Pima Foundation for Medical Care (hereinafter the "Pima Foundation") is an Arizona non-profit corporation with its principal place of business in Tucson, Arizona. The Pima Foundation is an association of doctors having four classes of members. Its "administrative members" are the members of the Board of Directors of the Pima Society. Its "participating members" are doctors who are qualified to be or are members of the Pima Society or the county medical society in any county contiguous to Pima County, Arizona. Its "cooperating members" are members of the Arizona Osteopathic Society or the Arizona Podiatry Society who reside in Pima County or in any county contiguous to Pima County, Arizona. Its "PSRO members" are providers of doctor's services to Federal Medicare patients. The Pima Foundation is controlled by the Pima Society. Over 70 percent of the doctors practicing in Pima County are participating or cooperating members of the Pima Foundation having a right to vote on the adoption of uniform fee schedules.

V

CO-CONSPIRATORS

9. Various individuals, partnerships, corporations and associations not named as defendants herein have participated as co-conspirators in the violations alleged herein and have performed acts and made statements in furtherance of those violations. Such co-conspirators include, without limitation, individual members, officers, directors, trustees and employees of each of the defendants; various doctors' associations and individual members and officers of those associations; and various individuals and corporations engaged in selling and underwriting health insurance in the State of Arizona.

VI
NATURE OF TRADE AND COMMERCE

10. Health care is a substantial industry in the United States and in the State of Arizona. In 1976, national health care expenditures totalled approximately $140 billion, while health care expenditures in the State of Arizona totalled approximately $1.3 billion. Health care costs have been increasing at a substantially greater rate than costs in other sectors of the economy. The disproportionate increase in health care costs has caused significant displacement in the economy of Arizona. In 1971 health care expenditures accounted for 7.4 per cent of Arizona's gross state product and 7.6 per cent of the gross national product; by 1976 health care expenditures accounted for 10.4 per cent of Arizona's gross state product, compared to 8.7 per cent of the gross national product. Between 1974 and 1976, the increase in health care expenditures in Arizona was 357 per cent greater than the increase in Arizona's gross state product.

11. There are approximately 3,750 doctors engaged in the practice of medicine in the State of Arizona; approximately 60 percent of those doctors are members of the Maricopa Society or Pima Society. During the period from 1966 to 1975, payments to doctors in the State of Arizona nearly tripled, climbing from approximately $75,867,000 in 1966 to approximately $218,379,000 in 1975. Doctors in Arizona receive and treat patients from other states, refer Arizona patients for treatment out-of-state, receive substantial sums of money which flow across state lines for medical services rendered in Arizona, and prescribe medicines and other goods and products which are shipped in interstate commerce and form an integral part of the interstate distribution of such prescription drugs, goods and products.

The practice of medicine involves the purchase, use and sale of goods and products which are manufactured and sold and flow in a continuous and uninterrupted stream of interstate commerce.

12. A substantial portion of the prices charged by doctors to patients are paid through health insurance. The State of Arizona and many of its citizens purchase health insurance and the premiums paid for such health insurance total approximately $350 million annually in the State of Arizona. The prices doctors charge for their services, goods and products have a direct and substantial effect upon payments made to and premiums charged by insurers. Health insurance involves a continuous and uninterrupted flow of services, products, contracts and claims in interstate commerce and the transfer of substantial sums of money across state lines.

13. Defendants Maricopa Foundation and Pima Foundation endorse certain health insurance plans (hereinafter referred to as "Foundation Plans") which are underwritten by private insurers in the State of Arizona and elsewhere and meet certain "minimum standards" formulated by defendants. Those minimum standards include, among other things, coverage of a wide range of services, goods and equipment sold by doctors. Defendants and their co-conspirators set the prices which the insurers must pay under Foundation Plans for covered services, goods and products sold by doctors to Foundation policyholders. Foundation Plans involve a substantial and uninterrupted flow of products, services, contracts and claims in interstate commerce and the transfer of substantial sums of money across state lines.

VII
VIOLATIONS ALLEGED

14. Beginning at a time unknown to plaintiff but believed to be on or about December 22, 1969, and continuing thereafter up to and including the filing of this Complaint, defendants and their co-conspirators have engaged in a con-

tinuing combination and conspiracy in unreasonable restraint of the aforesaid interstate trade and commerce in violation of Section 1 of the Sherman Act, 15 U.S.C. § 1. Plaintiff is informed and believes that said combination and conspiracy is continuing and may continue in the future unless the relief herein prayed for is granted.

15. The aforesaid combination and conspiracy consists of a continuing agreement, understanding and concert of action among the defendants and their co-conspirators, the substantial terms of which have been, among others:

(a) to fix, raise, maintain and stabilize prices charged by doctors;

(b) to establish and maintain uniform and agreed-upon systems for determining prices charged by doctors;

(c) to establish, maintain and revise uniform and agreed-upon relative value schedules;

(d) to fix, raise, maintain and stabilize unit conversion factors to be used in connection with the aforementioned relative value schedules;

(e) to control and restrain third party review of prices charged by doctors; and

(f) to reduce and eliminate price competition among doctors.

16. In formulating and effectuating the aforesaid combination and conspiracy, defendants and their co-conspirators did those things which they combined and conspired to do including, among other things:

(a) consulted with and surveyed doctors and doctors' associations with respect to current and desired prices for services, goods and products sold by doctors;

(b) consulted with and surveyed doctors and doctors' associations with respect to relative value schedules, unit conversion factors and other fee schedules used to determine prices for services, goods and products sold by doctors;

(c) prepared, adopted, maintained and published schedules of agreed-upon prices for services, goods and products sold by doctors;

(d) compiled, revised, maintained and published relative value schedules;

(e) compiled, revised, maintained and published schedules of unit conversion factors for use with relative value schedules;

(f) prepared, approved and published changes in relative value schedules, unit conversion factors and fee schedules after surveying and consulting with doctors and doctors' associations with respect to such changes;

(g) adhered to Foundation relative value schedules, unit conversion factors and fee schedules;

(h) entered into agreements with health insurers that the insurers pay for covered services, goods and products sold to Foundation policyholders by doctors at prices set by defendants and their co-conspirators;

(i) required as a term of membership in the Maricopa Foundation or Pima Foundation that Foundation members accept payment on assigned claims for services, goods and products sold to Foundation policyholders in accordance with Foundation fee schedules;

(j) gave advance notice of planned increases in Foundation fee schedules to health insurers so that the resulting increases in prices charged by doctors were passed on to Foundation subscribers through increased health insurance premiums;

(k) controlled the review and administration of claims for services, goods and products sold by doctors to Foundation policyholders.

VIII
EFFECTS OF THE CONSPIRACY

17. The aforesaid combination and conspiracy has had the following effects, among others:

(a) schedules of agreed-upon prices for services, goods and products sold by doctors have been regularly published to the majority of doctors in the State of Arizona;

(b) Foundation fee schedules have set an agreed-upon level for prices charged by doctors;

(c) prices for services, goods and products sold by doctors have been fixed, maintained and stabilized at artificial and non-competitive levels;

(d) prices for services, goods and products sold by doctors have been raised collectively to agreed-upon levels;

(e) uniform systems for setting the prices of services, goods and products sold by doctors have been established, maintained and stabilized;

(f) price competition in the sale of services, goods and products sold by doctors has been restricted, suppressed and restrained;

(g) purchasers of the services, goods and products sold by doctors have been deprived of the benefits of free and open competition and the right to obtain such services, goods and products at competitively determined prices;

(h) review by third party payors of the prices charged for doctors' services, goods and products has been restricted, suppressed and restrained;

(i) The cost of health insurance has been increased.

COUNT TWO

IX

18. Plaintiff repeats and realleges the allegations contained in Paragraphs 1 through 17 as if again set forth in full.

19. The aforementioned conduct of the defendants and co-conspirators violates Arizona Revised Statutes Annotated §§ 44-1401, *et seq.*, commonly known as the Uniform State Antitrust Act.

X

WHEREFORE, Plaintiff prays:

1. That the Court adjudge and decree that the aforesaid combination and conspiracy and the acts done in pursuance thereof were and are an unreasonable restraint of trade and commerce in violation of Section 1 of the Sherman Act, 15 U.S.C. § 1, and Arizona Revised Statutes Annotated § 44-1402.

2. That pursuant to Section 16 of the Clayton Act, 15 U.S.C. § 26, and Arizona Revised Statutes Annotated § 44-1408(B) the defendants and their members be permanently enjoined from continuing the violations of the law alleged in this Complaint and from entering into any combination, conspiracy, agreement, understanding or concert of action having a similar purpose or effect.

3. That pursuant to Section 16 of the Clayton Act, 15 U.S.C. § 26, and Arizona Revised Statutes Annotated § 44-1408(B) the Court enter such decree as may be required to restore competition in the sale of services, goods and products by doctors.

4. That defendants be required to distribute to each of their members a copy of the final judgment or decree entered by this Court within 60 days after entry of such judgment or decree.

5. That defendants' members be required to surrender to plaintiff within 120 days after the date of entry of the final judgment or decree all relative value schedules, schedules of unit conversion factors, other fee schedules and minimum standards for health insurance and all copies thereof in their possession.

6. That plaintiff recover from defendants the costs of this suit including a reasonable attorney's fee in accordance with Sections 4 and 16 of the Clayton Act, 15 U.S.C. §§ 15, 26, and Arizona Revised Statutes Annotated § 44-1408(B).

7. That plaintiff have such other, further or different relief as the law may require or the Court may deem just and proper.

(Signature omitted in printing.)

JURY DEMAND

PLEASE TAKE NOTICE that plaintiff demands a trial by jury pursuant to Rule 38(b), Federal Rules of Civil Procedure, of all issues triable of right by a jury.

(Signature omitted in printing.)

Filed - NOV. 2, 1978
W. J. Furstenau, Clerk
U. S. District Court
For The District of Arizona

(Caption omitted in printing.)

ORDER

Pursuant to stipulation of the parties,

IT IS ORDERED that:

1. On or before November 17, 1978, defendants shall file and serve motions permitted under Rule 12, Federal Rules of Civil Procedure, or answers to the complaint herein. Plaintiff will file and serve its response to all Rule 12 motions filed by defendants on or before November 27, 1978 and defendants will file and serve their reply papers on or before December 4, 1978. All such motions will be set for hearing on December 11, 1978, at 10:00 a.m.

2. Defendants shall file and serve their responses to plaintiff's First Request for Admissions and Interrogatories on Rule 42C within one week following the meeting of counsel pursuant to Local Rule 42A. The Court shall then set a pre-hearing conference pursuant to Local Rule 42D and a date for hearing plaintiff's motion for preliminary injunction which will be as soon after the pre-hearing conference as possible and prior to April 30, 1979.

6. For the purpose of maintaining the status quo until plaintiff's preliminary injunction motion may be heard, until the earlier of May 1, 1979, or final judgment for any party in this action, or further order of this Court, no defendant, nor any officer, agent, servant, employee or attorney of any defendant nor any person in active concert or participation with any defendant who receives actual notice of this order by personal service or otherwise shall participate in any survey, agreement, vote or other step to

establish, determine or disseminate any relative value or conversion factor with respect to medical services, goods or products other than those relative values and conversion factors in effect on or before October 18, 1978.

DONE IN OPEN COURT this 2 day of November, 1978.

/s/

Honorable Willie [illegible]. Copple,
Judge, United States District Court

Filed - NOV. 15, 1978
W. J. Furstenau, Clerk
U. S. District Court
For The District of Arizona

ANSWER OF DEFENDANT PIMA FOUNDATION FOR MEDICAL CARE

The defendant, Pima Foundation for Medical Care, an Arizona non-profit corporation, answers the Complaint as follows:

COUNT ONE

I

While it admits that the plaintiff claims the jurisdiction of this Court under the statute recited in Paragraph 1 of the Complaint, it denies that in fact this Court has jurisdiction over it in this matter.

II

It denies that it is engaged in interstate commerce, either within or from the District of Arizona, or that any of its acts are within the flow of interstate trade and commerce or have any direct or substantial effect on such trade or commerce.

III

It denies the status of the State of Arizona to bring this action and it denies further that the State or its citizens purchased "substantial amounts of doctors' services and health insurance" which is affected in any way by the activities of this defendant.

IV

It admits the allegations of Paragraph IV referable to it except that it specifically denies that it has four classes of members, affirmatively alleging that it has in fact three classes of members and that it has no "PSRO members" at

all; and it further denies that over 70% of the doctors practicing in Pima County are participating or cooperating members of the Foundation or have anything whatever to do with the Foundation or its structure.

V

It denies the allegations of Paragraph V.

VI

It admits that health care is a substantial industry in the United States and in the State of Arizona, and it has no information sufficient to enable it to form any belief as to the truth of the allegations of Paragraph VI(10), and hence denies them all; it admits the allegations of the first sentence of Paragraph VI(11); and it has no information sufficient to enable it to form any belief as to the truth of the allegations of the remainder of (11) and hence denies them all.

VII

It denies that health insurance, to the extent that it is in any way applicable to the activities or structure of this defendant, involves a continuous and uninterrupted flow of services, products, contracts and claims in interstate commerce or the transfer of substantial sums of money across state lines, and otherwise admits the allegations of Paragraph VI(12).

VIII

It denies that it and others set the prices which insurers must pay under Foundation plans for covered services, goods and products sold by doctors to Foundation policyholders; it denies further that its plan or it itself involves a substantial and uninterrupted flow of products, services, contracts and claims in interstate commerce and the transfer of substantial sums of money across state lines; and it admits the remaining allegations of Paragraph VI(13).

IX

It denies every allegation of Paragraph VII in all its parts, and all of the allegations of Paragraph VIII in all its parts, and every other allegation of the Complaint, including all the allegations of Count Two not specifically admitted when included in Count One.

AFFIRMATIVE DEFENSES

I

As a further and alternative defense, this defendant avers that the Court is without jurisdiction over the subject matter of the Complaint against this defendant in this case.

WHEREFORE, this defendant prays for judgment in its favor on the Complaint, for its costs herein incurred, and for all other appropriate relief.

(Signature omitted in printing)

Filed - NOV. 17, 1978
W. J. Furstenau, Clerk
U. S. District Court
For The District of Arizona

(Caption omitted in printing.)

DEFENDANT MARICOPA FOUNDATION FOR MEDICAL CARE'S MOTION TO DISMISS THE COMPLAINT

Defendant Maricopa Foundation for Medical Care, moves the Court pursuant to Rules 12(b) (1) and (6) of the Federal Rules of Civil Procedure for an order dismissing the complaint herein for lack of jurisdiction over the subject matter and failure to state a claim upon which relief can be granted. This motion is based upon the complaint herein, the attached Memorandum and the affidavit of Anthony D. Mitten sworn to November 17, 1978.

(Signatures omitted in printing.)

Filed - NOV. 17, 1978
W. J. Furstenau, Clerk
U. S. District Court
For The District of Arizona

(Caption omitted in printing.)

MEMORANDUM IN SUPPORT OF DEFENDANT MARICOPA FOUNDATION FOR MEDICAL CARE'S MOTION TO DISMISS THE COMPLAINT

THE ACTIVITIES OF MARICOPA FOUNDATION WHICH PLAINTIFF ALLEGES TO BE UNLAWFUL ARE EXEMPTED FROM THE FEDERAL ANTITRUST LAWS BY THE McCARRAN-FERGUSON ACT BECAUSE THEY CONSTITUTE THE "BUSINESS OF INSURANCE" AND ARE REGULATED BY ARIZONA.

Although the allegations of the complaint are vague and ambiguous (see Defendant's Motion for a More Definite Statement), it is clear from plaintiff's Memorandum in Support of Application for Order to Show Cause and Motion for Preliminary Injunction, dated October 25, 1978, that the activity of Maricopa Foundation for Medical Care ("Maricopa Foundation") which plaintiff contends to be unlawful consists of its endorsement, promotion and administration of heath insurance plans.

> "*The framework for the defendants' unlawful combination lies in agreements between the foundations and certain health insurers.* Under those agreements the foundations endorse, promote and administer certain health insurance plans (hereinafter 'foundation plans') which are underwritten by the insurers. In return, the insurers must provide coverage for the wide range of doctors' services set out in the foundations' minimum standards and agree to pay for covered services, goods and products sold by doctors to foundation policyholders at the prices fixed by the foundation fee schedule. As a term of membership in the foundation, doctors agree to accept the prices fixed

by the foundation fee schedule as full payment for assigned claims of foundation policyholders. The doctors submit such assigned claims directly to the foundations. The review and payment of those claims is performed by foundation members; in the case of specialists, the review is performed by members of the same specialty."

Pages 4-5. (Emphasis added)

As plaintiff states in its complaint, "Defendants Maricopa Foundation and Pima Foundation endorse certain health insurance plans (hereinafter referred to as 'Foundation Plans') which are underwritten by private insurers in the State of Arizona and elsewhere and meet certain 'minimum standards' formulated by defendants. Those minimum standards include, among other things, coverage of a wide range of services, goods and equipment sold by doctors. Defendants and their co-conspirators set the prices which the insurers must pay under Foundation Plans for covered services, goods and products sold by doctors to Foundation policyholders."

(Paragraph 13). The complaint further alleges that the Sherman Act Section 1 violation consists of a conspiracy, pursuant to which Maricopa Foundation

"(h) entered into agreements with health insurers that the insurers pay for covered services, goods and products sold to Foundation policyholders by doctors at prices set by defendants and their co-conspirators;

(i) required as a term of membership in the Maricopa Foundation or Pima Foundation that Foundation members accept payment on assigned claims for services, goods and products sold to Foundation policyholders in accordance with Foundation fee schedules;

(j) gave advance notice of planned increases in Foundation fee schedules to health insurers so that the resulting increases in prices charged by doctors were passed on to Foundation subscribers through increased health insurance premiums;

(k) controlled the review and administration of claims for services, goods and products sold by doctors to Foundation policyholders."

(Complaint, paragraph 16).

The complaint further alleges "The prices doctors charge for their services, goods and products have a direct and substantial effect upon payments made to and premiums charged by insurers" (paragraph 12) and that an effect of the alleged conspiracy is that "The cost of health insurance has been increased." (Complaint, paragraph 17) Maricopa Foundation does not believe that the allegations of the complaint or charges in the preliminary injunction papers accurately represent the functions of the Maricopa Foundation, particularly in their unfounded accusations that Maricopa Foundation has increased the price of medical services. The facts will prove, to the contrary, that Maricopa Foundation has been a substantial factor in reducing the cost of medical services and retarding price increases. Nevertheless, it is respectfully submitted that the allegations of the complaint, viewed in light of the admissions by plaintiff in its Motion for Preliminary Injunction, demonstrate that Maricopa Foundation is exempted from the federal antitrust laws by the McCarran-Ferguson Act.

The McCarran-Ferguson Act, 15 U.S.C. §§ 1011-1015,[1] exempts the "business of insurance" from application of the Sherman Act to the extent that such business is regulated by state law. In construing the Act, federal courts consistently have held that the "business of insurance" is not limited to activities of insurance companies; the focus of the exemption is on the nature of the conduct under attack, not on the nature of the entity engaging in the challenged conduct. If challenged activities touch upon the "core of the 'business of insurance,' " defined by the Supreme Court to include "the fixing of rates . . . the selling and advertising of policies . . . the type of policy which [can] be issued, its reliability, interpretation, and enforcement . . . ,"[2] and if they are subject to regulation by state law, federal laws which might otherwise supersede the state regulatory scheme do not apply. *E.g., Lowe v. Aarco-American, Inc.*, 536 F.2d 1160, 1162 (7th Cir. 1976) (applying the McCarran-Ferguson Act to exempt an insurance broker and a premium finance company from the Turth in Lending Act; "the fact that neither appellee is an insurance company does not take the disputed transaction outside the scope of the 'business of insurance' "); *General Glass Co., Inc. v. Globe Glass and Trim Co.*, [1978-1]

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[1] 15 U.S.C. § 1012 provides:

(a) The business of insurance, and every person engaged therein, shall be subject to the laws of the several States which relate to the regulation or taxation of such business.

(b) No Act of Congress shall be construed to invalidate, impair, or supersede any law enacted by any State for the purpose of regulating the business of insurance, or which imposes a fee or tax upon such business, unless such Act specifically relates to the business of insurance: *Provided*, That after June 30, 1948, the Act of July 2, 1890, as amended, known as the Sherman Act, and the Act of October 15, 1914, as amended, known as the Clayton Act, and the Act of September 26, 1914, known as the Federal Trade Commission Act, as amended, shall be applicable to the business of insurance to the extent that such business is not regulated by State law.

[2] *SEC v. National Securities, Inc.*, 393 U.S. 453, 459-60 (1969) (reversing a decision which applied the McCarran-Ferguson Act to exempt from the federal securities laws a contemplated merger of insurance companies because the state regulatory scheme did not constitute regulation of the business of insurance).

Trade Reg. Rep. (CCH) ¶ 62,231 (N.D. Ill. Sept. 13, 1978) (granting summary judgment for defendant auto glass replacement firms because their agreements with respect to pricing and billing procedures with automobile insurers constituted the business of insurance; "the claims-settlement procedures have a direct connection with an insurance company's ratemaking structure. Almost axiomatic is the fact that the cost of repairs, including labor charges . . . paid in settlement of damage claims are an important factor in the ratemaking structure." *Id.* at 75,489).

A. The Foundation is Engaged in the "Business of Insurance".

With the exception of one decision, the appeal from which is now sub judice in the Supreme Court, federal courts which have considered applicability of the McCarran-Ferguson Act to agreements among suppliers of health care services and insurers have held the agreements to constitute the "business of insurance" because of their direct impact upon the insurance ratemaking process.[3]

In a case strikingly similar to this, *Anderson v. Medical Service*, [1976-1] *Trade Reg. Rep.* (CCH) ¶ 60,884 (E.D. Va. Feb. 10, 1976), *aff'd mem.*, 551 F.2d 304 (4th Cir. 1977), the court dismissed the Sherman Act complaint filed by a physician against a non-profit corporation engaged in selling prepaid medical services because Medical Service's activities were part of "the business of insurance". Like the Maricopa Foundation's insurance plans, Medical Service patients who were treated by participating physicians pursuant to its UCR plan were assured that their treatment would be fully paid by their insurance because those physicians had agreed to accept

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[3] *Royal Drug Co. v. Group Life & Health Ins. Co.*, 556 F.2d 1375 (5th Cir. 1977), *cert. granted*, 98 Sup. Ct. 1448 (1978) stands virtually alone in its holding that a prepaid pharmaceutical insurance plan, which involved an agreement by pharmacies to provide drugs at pre-determined rates, did not constitute the business of insurance. The matter was argued to the Supreme Court on October 11, 1978, but it has not yet rendered its opinion. [1978] *Trade Reg. Rep.* (CCH) ¶ 60,021.

the insurer's payment as payment in full, even though the physician's usual and customary fees may have been higher. (Mitten aff., para. 4) The level of reimbursement under the UCR plan was ordinarily the physician's usual and customary fee charged for the services rendered up to a maximum reimbursement level set by Medical Service. The Maricopa Foundation and Medical Service UCR plans are parallel in other significant respects: (1) in both patients are in no way restrained from seeking treatment from non-participating physicians—they receive exactly the same benefits regardless of the service provider; in both cases they are, however, liable for physician fees exceeding the maximum level of benefits if a non-participating physician charges more than the plan's maximum reimbursement level (Mitten aff., para. 4); (2) a significant percentage of area physicians are enrolled as participating members of the corporations;[4] (3) the contracts between participating physicians and each corporation are "nothing more than an agreement on the part of the doctor to accept as full payment for medical services rendered Medical Service's policyholders the charge computed by the UCR formula." [1976-1] *Trade Reg. Rep.* (CCH) ¶ 60,884 at 68,857; Mitten aff., para. 3; and (5) physicians charge their patients, including Foundation or Medical Service plan patients, whatever they deem proper.[5] *Id.* at 68,858; Mitten aff., para. 3.

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[4] The complaint alleges over 70% of the licensed physicians in Maricopa County are enrolled in the Maricopa Foundation as participating members (para. 8(b)) while 93% of the practicing physicians in the Washington metropolitan area were enrolled in Medical Service. [1976-1] *Trade Reg. Rep.* (CCH) ¶ 60,884 at 68,856.

[5] Moreover, Foundation physicians expressly agree as a condition of membership that their participation in the plan will not affect the method or amount they *charge* their patients for services rendered. Their only agreement, in connection with compensation, is to accept as payment in full the level of reimbursement provided under the Foundation plan. [Mitten aff., para. 3, 4; Ex. A]

Another prepaid health care services insurance program, strikingly parallel to the Foundation plan, was found exempt from federal antitrust attack in the leading decision on applicability of the McCarran-Ferguson Act to health care within the Ninth Circuit. *Manasen v. California Dental Services*, 424 F. Supp. 657 (N.D. Cal. 1976).[6] Accepting the well-established notions that "the 'business of insurance' may embrace arrangements between insurance companies and nonpolicyholders, including service providers" and that "a wide variety of activities which have a substantial effect on ratemaking, including the settlement of claims and the limitation of costs. . . ," the court held that California Dental Service's (CDS) payment arrangements to the providers of health services constituted the "business of insurance" within the meaning of the McCarran-Ferguson Act and granted CDS' motion for summary judgment. 424 F. Supp. at 666. In reaching its decision, the court stated:

> "Plaintiffs here contend that it is an antitrust violation for CDS to pay service providers prevailing rates for the services rendered to insured patients. It is undisputed that the level of dentists' fees are a major factor in determining policy premiums. CDS' payment

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[6] Like CDS, the Foundation offers prepaid health care services under which subscribers pay periodic premiums in exchange for the agreement of the Foundation membership to provide designated services at predetermined rates. While CDS assumed direct actuarial risk, independent insurance carriers or self-insurers assume that risk under the Foundation plan. Mitten aff., para. 2. The distinction is immaterial, however, because in CDS as here, "the plaintiffs' primary challenge is directed at the method and manner by which CDS compensates those dentists who provide the services for which CDS accepts claims and underwrites risks. 424 F. Supp. at 665. The manner of compensation at issue in *Manasen*, like the manner of compensation at issue here, involved the agreement of participating dentists to accept as full reimbursement payment provided by CDS pursuant to a pre-established schedule. CDS schedule limited compensation to the ninetieth percentile of the usual, customary and reasonable fees charged by area dentists for any particular procedure, unless a peer review group determined that a higher fee was reasonable under the circumstances. 424 F. Supp. at 661.

> arrangements to service providers are critical elements in CDS' contractual agreements with its subscribers. These arrangements are intimately related to the interpretation and implementation of CDS' policies and to its reliability as an insurer. Accordingly, the Court finds that the activities challenged in the instant complaint constitute part of the "business of insurance" within the meaning of the McCarran Act." (footnotes omitted)

424 F. Supp. at 666-67.

Similarly, the level of the Foundation's reimbursement to participating physicians is a major factor in determining the policy premiums of the group insurance plans it endorses. In establishing premium rates, underwriters use the Foundation's reimbursement levels as the basis for their actuarial calculations. Plaintiff so alleges in the complaint. Para. 12, 13, 16(j), 17(i). According to *Manasen*, the close relationship of the Foundation's compensation schedule, together with its claims processing activities, without more, is sufficient to bring its challenged activities within the business of insurance.

A series of cases in a related health services area—hospital care—further compel the conclusion that the very activities which the State of Arizona alleges to be violative of the federal antitrust laws clearly constitute the "business of insurance." *E.g., Travelers Ins. Co. v. Blue Cross*, 481 F.2d 80 (3d Cir.), *cert. denied*, 414 U.S. 1093 (1973) (antitrust claim alleging that Blue Cross' standard contract entered into with more than one hundred hospitals in Western Pennsylvania, prescribing the terms and amounts of compensation to be paid the providers for hospital care rendered to Blue Cross subscribers, dismissed because the agreements were within the "business of insurance."); *Frankford Hospital v. Blue Cross*, 417 F. Supp. 1104 (E.D. Pa. 1976), *aff'd per curiam*, 554 F.2d 1253 (3d Cir.), *cert. denied*, 434 U.S. 860 (1977); *Doctors, Inc. v. Blue Cross*, 431 F. Supp. 5 (E.D. Pa. 1975), *aff'd per curiam*, 557 F.2d 1001 (3d Cir. 1976); *Nankin Hospital v. Michigan Hospital Ser-*

vice, 361 F. Supp. 1199 (E.D. Mich. 1973); *Winters v. Kansas Hospital Service Ass'n, Inc.*, [1975] *Trade Reg. Rep.* (CCH) ¶ 60,140 (D. Kan. Dec. 26, 1974).

B. The State of Arizona Regulates Maricopa Foundation's Activities.

The conduct which the State of Arizona challenges, including entering into agreements with insurers and engaging in claims processing and review,[7] are clearly regulated by the States' own comprehensive statutory insurance scheme. No only are the challenged insurance agreements (which incorporate the provisions of the Foundation's minimum standards) subject to regulation by the Arizona Department of Insurance[8] but the activities of the Foundation itself are directly regulated by that administrative agency. [Mitten aff. paras. 5-6] As an insurance administrator,[9] the Maricopa Foundation may not act "without a written agreement between [the Foundation] and an insurer,[10] and the agreement, which is subject to audit and review by the director of insurance,[11] must contain provisions "with respect to the underwriting or other

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[7] The State alleges at paragraphs 16(h) and (k) of its complaint that the Foundation "entered into agreements with health insurers that the insurers pay for covered services, goods and products sold to Foundation policyholders by doctors. . . ." and "controlled the review and administration of claims for services, goods and products sold by doctors to Foundation policyholders."

[8] *See generally* A.R.S. § 20-1341 to 20-1376 and §§ 20-1401 to 20-1406, pertaining to disability insurance, defined by A.R.S. § 20-253 to include "expense resulting from sickness, and every insurance appertaining thereto" and A.R.S. §§ 20-441, -442 and -446 prohibiting unfair trade practices in the business of insurance.

[9] The Foundation was notified by the Director of the Department of Insurance in January 1978, that it was an "insurance administrator" within the meaning of A.R.S. § 20-485 and therefore subject to regulation by that department. The Foundation has registered pursuant to A.R.S. § 20-485.12. [Mitten aff., paras. 5-6]

[10] A.R.S. § 20-485.01(A).

[11] A.R.S. § 20-485.03.

standards pertaining to the business underwritten by such insurer."[12]

The Insurance Laws of Arizona contain in Title 20, Chapter 2, Article 6, A.R.S. a number of sections giving the Department of Insurance power to prevent unfair practices. A.R.S. § 20-441 provides:

> "Among the purposes of this article is the regulation of trade practices in the business of insurance in accordance with the intent of Congress as expressed in the Act of Congress of March 9, 1945, 59 Stat. 33 [15 U.S.C.A. § 1011 et seq.], by defining, or providing for the determination of, all such practices in this state which constitute unfair methods of competition or unfair or deceptive acts or practices and by prohibiting the trade practices so defined or determined."

Even absent the specific provisions of the Insurance Laws regulating the Maricopa Foundation, it would still be exempted from the Sherman Act by the McCarran-Ferguson Act. It is not necessary that the state regulatory scheme "seek to implement the policies expressed in the federal antitrust laws," nor is it necessary that the scheme be effective. "Indeed, the mere existence of regulatory statutes capable of being enforced is sufficient to invoke the protection of the McCarran Act." *Manasen v. California Dental Services*, 424 F. Supp. at 667. *Accord, Commander Leasing Co. v. Transamerica Title Ins. Co.*, 477 F.2d 77, 84 (10th Cir. 1973); *Ohio AFL-CIO v. Insurance Rating Board*, 451 F.2d 1178, 1184 (6th Cir. 1971), *cert. denied*, 409 U.S. 917 (1972); *California League of Independent Ins. Producers v. Aetna Casualty & Surety Co.*, 175 F. Supp. 857, 860 (N.D. Cal. 1959) ("... a State regulates the business of insurance ... when a State statute generally proscribes ... or permits or authorizes certain conduct on the part of the insurance companies.")

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[12] A.R.S. § 20-485.05.

Because the activities of the Foundation, as set forth in the State of Arizona's complaint, constitute the "business of insurance" subject to regulation by the State, the McCarran-Ferguson Act exempts the Foundation from application of federal antitrust laws and Count One of the complaint, therefore, should be dismissed.

IF PLAINTIFF'S FEDERAL ANTITRUST CLAIM IS DISMISSED, THE STATE ANTITRUST CLAIMS SHOULD BE DISMISSED AS WELL.

Plaintiff's complaint alleges two causes of action. Count One alleges violations of Section 1 of the Sherman Act, 15 U.S.C. § 1, with jurisdiction conferred by 28 U.S.C. § 1331 and 1337 and 15 U.S.C. § 26. Count Two alleges violations of the Uniform State Antitrust Act. A.R.S. §§ 44-1401, *et seq.* The sole basis alleged by plaintiff to give this Court jurisdiction over the state law claim of Count Two is pendent jurisdiction. (Complaint, paragraph 2). If the federal claims of Count One are dismissed, the basis for pendent jurisdiction would no longer exist and the state law claim should also be dismissed for lack of subject matter jurisdiction pursuant to Fed. R. Civ. P. 12(b)(1).

The landmark case on pendent jurisdiction is *United Mine Workers of America v. Gibbs*, 383 U.S. 715, 726 (1966). In that decision, Justice Brennan explained the principles of pendent jurisdiction as follows:

> "It has consistently been recognized that pendent jurisdiction is a doctrine of discretion, not of plaintiff's right. Its justification lies in considerations of judicial economy, convenience and fairness to litigants; if these are not present a federal court should hesitate to exercise jurisdiction over state claims ... *Certainly, if the federal claims are dismissed before trial, even though not insubstantial in a jurisdictional sense, the state claims should be dismissed as well.*" (Emphasis added.)'

The situation described by Justice Brennan exists in this case. If the federal claims are dismissed with respect to Maricopa Foundation, it would be an abuse of discretion not to also dismiss the state claims.

Numerous Ninth Circuit decisions have applied the principle set forth above to dismiss state law pendent claims not decided on their merits prior to dismissal of all claims over which the federal court had statutory jurisdiction. *Hodge v. Mountain States Tel. & Tel. Co.*, 555 F.2d 254, 261 (9th Cir. 1977), (Affirming the district court's summary judgment for defendant on the federal claims; "remand[ing] the state law claims to the district court with instructions to dismiss for want of federal jurisdiction."); *Toensing v. Brown*, 528 F.2d 69, 72 (9th Cir. 1977), (Affirming the district court's summary judgment for defendant on the federal claim and the dismissal of the pendent state claim. "Upon dismissal of the federal claim before trial, a proper exercise of discretion required dismissal of the pendent state claim."); *National Ass'n of B.E.T. v. International All. of T.S.E.*, 488 F.2d 124 (9th Cir. 1973), (Affirming the district court's dismissal of the federal antitrust claim on the pleadings and the dismissal of the pendent state claim.); *Walling v. Beverly Enterprises*, 476 F.2d 393, 398 (9th Cir. 1973), (Reversing and remanding dismissal of a federal securities claim for lack of subject matter jurisdiction with instruction that "... if the federal claim is dismissed prior to trial, the state claims should be dismissed as well so that federal jurisdiction will not be abused."); *Wham-O-Mfg. Co. v. Paradise Mfg. Co.*, 327 F.2d 748, 753 (9th Cir. 1964) (Affirming dismissal of a federal claim for patent infringement and a state claim for unfair competition. The district court acting sua sponte had dismissed the unfair competition claim. Once the federal

claim was dismissed, on summary judgment, the district court, "in the exercise of a sound discretion, had no choice but to dismiss the complaint with respect to [the state] claim.")

On the basis of the foregoing cases, if the federal claims of Count One are dismissed or sticken, defendant respectfully requests this Court to dismiss without prejudice the state law claim of Count Two for lack of subject matter jurisdiction.

Conclusion

For the foregoing reasons, plaintiff's complaint should be dismissed in its entirety.

November 17, 1978.

(Signatures omitted in printing.)

(Caption omitted in printing.)

AFFIDAVIT OF
ANTHONY D. MITTEN

STATE OF ARIZONA }
} ss.
County of Maricopa }

ANTHONY D. MITTEN, being duly sworn, under oath deposes and says:

1. I am the Executive Director of defendant Maricopa Foundation for Medical Care ("Maricopa Foundation") herein. I make this affidavit in support of Maricopa Foundation's Motion to Dismiss the Complaint.

2. The Maricopa Foundation was established to provide residents of Maricopa County with a competitive alternative to utilization of closed panel prepaid health insurance plans. Its activities include establishment of minimum standards for insurance plans for which Maricopa Foundation will perform peer review and administrative functions. Maricopa Foundation reviews the medical necessity and appropriateness of treatment and, for certain insured groups, also reviews utilization of hospital services. Following the medical review by the Maricopa Foundation, it makes payment on claims for certain insured groups. In each instance, Maricopa Foundation acts as an agent of an insurer who underwrites the health insurance plan. When Maricopa Foundation pays claims, it draws funds from bank accounts of the insurer with respect to which it has the power to issue drafts as the insurer's agent.

3. Membership in Maricopa Foundation is open to all physicians licensed to practice in Arizona without regard to whether they are members of any medical society. Each participating member in Maricopa Foundation executes an application for membership, a true copy of which is attached hereto as Exhibit "A". That application for membership specifically states "I understand and agree that participating membership in the Foundation shall not

affect the method of computation or amount of fees billed by me with respect to any medical care for any patient." Participating members further agree "to be bound during the period of the membership applied for with respect to maximum fees charged patients covered by Foundation sponsored plans by any fee determination by the Foundation consistent with the schedule adopted by the membership and agree also to be bound with respect to patients covered by Foundation sponsored plans during the period of membership applied for by any agreements, contracts, or statements of policy entered into or adopted by the Foundation concerning the rendering of medical care and the cost thereof."

4. The only determinations with respect to fees charged for medical services which are made by Maricopa Foundation are with respect to maximum fees paid with respect to patients covered by Foundation endorsed plans to participating members in Maricopa Foundation. They agree to accept the Foundation's determination of maximum fees as payment in full for services performed by them on patients covered by Foundation endorsed plans when they bill the patient more than that amount. If the patient is billed less than that amount, the physician is paid the amount billed if the services are determined by Maricopa Foundation to have been medically appropriate. Maricopa Foundation does not and never has taken any position with respect to the amount of fees a participating member or other physician should bill with respect to any medical care for any patient. Patients covered by Foundation endorsed plans receive the same insurance benefits with respect to treatment by physicians who are not participating members as they would receive if treated by a participating member.

5. In 1977, Arizona enacted Article 9 to Title 20, Chapter 2 of Arizona Revised Statutes, the Title pertaining to regulation of the business of insurance in Arizona. That Article, which became effective August 27, 1977, provides for regulation by the Department of Insurance of the State of

Arizona of "insurance administrators" as defined in A.R.S. § 20-485. After enactment of Chapter 9, I consulted with Jack Trimble, Director of the Arizona Department of Insurance, as to whether Maricopa Foundation was an insurance administrator as defined by A.R.S. § 20-485. In January 1978, I received a response to my inquiry to Mr. Trimble from Clarence E. Newman, Jr. auditor in the Department of Insurance of the State of Arizona, informing me that "It has been determined that the functions that your organization performs are within the definition of an insurance administrator as defined under § 20-485 of the Insurance Administrators' Law" and enclosing forms to be completed by Maricopa Foundation in order to register under that law.

6. Maricopa Foundation has submitted registration forms to the Department of Insurance of the State of Arizona in the form required by it and those forms have been accepted by the State of Arizona Department of Insurance. As a result, Maricopa Foundation is duly regulated by the Department of Insurance of the State of Arizona under the insurance laws of the State of Arizona.

(Signature and notarization
omitted in printing.)

Filed - NOV 20, 1978
W. J. Furstenau, Clerk
U. S. District Court
For The District of Arizona

ıtion omitted in printing.)

Deposition of MARY GERDENICS

November 14, 1978

Tucson, Arizona

[4]

* * * Would you please state your name and home ess?

Mary Gerdenics, 2001 West Brichta; Tucson, Arizona, i-c-h-t-a.

* * * *

By whom are you employed?

The Greater Southern Arizona PSRO.

What is your position with the Greater Southern Ari- PSRO?

I'm the administrative assistant.

What are your responsibilities as Administrative As- nt of the Greater Southern

[5]

ɔna PSRO?

Okay. I'm the bookkeeper; I take care of all the ac- ts; I'm responsible for the over-all running of the e, itself, as far as —

And how long have you held that position.

Since October, 1977.

What position did you hold prior to becoming the inistrative assistant for the Greater Southern Arizona O?

A. I was the executive secretary for the Pima Foundation for Medical Care.

Q. What were you responsibilities as Executive Secretary for the Pima Foundation for Medical Care?

A. I was the bookkeeper and secretary to the board of directors.

* * * *

[20]

Q. Would you briefly describe the method in which the Pima Foundation performs claims' payment on Foundation plans and when I say "Foundation plans," let us understand that I'm referring to — A. Uh-huh.

Q. — plans that are endorsed by the Pima Foundation.

A. Well, I don't pay claims myself, so I don't know how they do them, but I know they follow the guidelines established by the insurance companies involved, so — But, how they pay claims, I don't know. I don't know the actual process.

Q. As the bookkeeper and secretary to the board for the Pima Foundation, was it your understanding that the Foundation paid claims specifically in accordance with the guidelines of the insurance companies that underwrote those policies?

A. Yes, they have to follow their guidelines, establised guidelines.

Q. The Pima Foundation does not assume any actuarial risk or underwrite any actuarial risk under Foundation plans; is that correct? A. That's correct.

* * * *

[25]

* * * *

Q. . . . [H]ow would you use the numbers to determine the allowable price?

A. Well, say an office visit would have a 1.0 units assigned; you would multiply your 1.0 units times your medicine schedule to come up with what you would pay for that particular procedure?

Q. So, in other words, you would multiply the dollar amount in the appropriate category times the relative value accorded a specific procedure? A. Yes, un-huh.

Q. In order to determine a price, then, with the Foundation fee schedule, it is necessary to use a relative value schedule? A. Yes, uh-huh.

Q. And conversely, the relative value schedule is part of the fee schedule of the Pima Foundation? A. Yes, uh-huh.

* * * *

[28]

* * * *

Q. In Paragraph Three of Exhibit 6, the letter states: The Foundation plan to be offered meets the minimum standards of the Pima Foundation for Medical Care for plans to be presented as under our auspices. A. Um-hum.

Q. Does a plan have to meet all minimum standards of the Pima Foundation in order to be presented under the auspices of the Pima Foundation? A. Yes.

Q. Paragraph Four, Number One, states that Pima Foundation for Medical Care members are to abide by a fee schedule related to 1964 CRV and there follows a list of medical categories with a dollar amount next to each cagetory. Does this mean that the Pima Foundation members have agreed to abide by the use of the 1964 California Relative Value Schedule with those conversion factors? A. Yes.

Q. Are the numbers used to multiply the relative values in the California Relative Value Schedule commonly referred to as conversion factors? A. Yes, they are.

Q. So if I use the term "conversion factors" to identify those dollar amounts, we'll understand each other?

A. It's easier to understand, yes.

Q. Correct? A. Yes, uh-huh.

Q. .In Subparagraph Four on Page One of Exhibit 6, the letter states that: The Foundation agrees to request the Maricopa Foundation to honor this program according to our previous agreements with the Maricopa Foundation to give the program broader state coverage.

[29]

What type of agreements does the Pima Foundation have with the Maricopa Foundation which would give such a program broader state coverage?

A. The Pima and Maricopa physicians agree to the same contract — What I mean is if a member — If someone who has a Pima Foundation contract would go to Phoenix to a physician who is a member of the Maricopa Foundation, then they would — It was if they were going to a Pima Foundation physician; they would not be charged for the difference. It is almost as if they, belonging to one organization, you belong to the other.

Q. So, it — A. I'm not saying this very well, but that's the only way I can —

Q. Would it be correct to say, then, that the members of the Maricopa Foundation honor the fee schedule agreed to by the members of the Pima Foundation?

A. Yes, on a given contract.

Q. And conversely, do the members of the Pima Foundation agree to use or to recognize on certain contracts the fee schedule agreed to by the members of the Maricopa Foundation? A. Yes, uh-huh.

* * * *

[30]

* * * *

Q. .... At what time did the Foundation begin to pay claims?

A. I think it was in January, 1976.

* * * *

[47]

Q. If you would be kind enough to clarify for me the manner in which this [California Relative Value Schedule and the ASA Guide] is used.

At Page Nine, taking a simple value, Procedure 9004 under medicine is labeled as: Follow-up Office Visit, Routine, and has a unit value of one; is that correct?

A. Yes, uh-huh.

Q. If the conversion factor for medicine is ten, then the fee charged for a routine follow-up office visit would be ten? A. Yes, uh-huh.

Q. And if the conversion factor for medicine is 12, then the fee charged for a routine follow-up office visit is 12? A. Yes.

Q. If the value of Procedure 9004 labeled: Follow-up Office Visit, Routine, were increased to 1.5, then the price of that office visit would be increased by 50 percent; is that correct? A. Yes, uh-huh.

Q. And if the doctor were a surgeon or anesthetist, would he still use the conversion

[48]

factor for medicine to compute the price for services listed in the medicine section of the California Relative Value Schedule? A. I don't understand exactly —

Q. Does the choice of conversion factor depend on the category of the procedure within the relative value schedule, or the specialty of the particular doctor? A. The procedure.

Q. I see. So, the categorization of the conversion factors into those five or six categories refers to sections of the relative value schedule — A. Yes.

Q. — rather than to a person's actual — A. Yes.

Q. — method of practice or category of practice. I see.

Just to clarify again, then, if the unit value of one procedure is increased, the price is increased only for that one procedure; is that right? A. Yes, if you only increase one.

Q. Okay, but if the conversion factor is increased, it raises the prices of all the procedures within the category of that conversion

[49]

factor? A. Yes.

* * * *

Filed - NOV 20, 1978
W. J. Furstenau, Clerk
U. S. District Court
For The District of Arizona

(Caption omitted in printing.)

PLAINTIFF'S MOTION FOR PARITAL SUMMARY JUDGMENT ON THE ISSUE OF LIABILITY AND NOTICE OF HEARING

Plaintiff STATE OF ARIZONA moves pursuant to Rule 56(a), Federal Rules of Civil Procedure, for entry of an order awarding partial summary judgment in its favor and against defendants that defendants' actions are in violation of section 1 of the Sherman Act, 15 U.S.C. § 1, and the Uniform State Antitrust Act, Ariz. Rev. Stat. Ann. § 44-1402. This motion is based upon the accompanying statement of facts and memorandum of law and the entire record herein.

PLEASE TAKE NOTICE that this motion will be heard on December 11, 1978 at 10:00 a.m.

DATED this 20th day of November, 1978.

(Signatures omitted in printing.)

Filed - NOV 20, 1978
W. J. Furstenau, Clerk
U. S. District Court
For The District of Arizona

(Caption omitted in printing.)

MEMORANDUM IN SUPPORT OF PLAINTIFF'S MOTION FOR PARTIAL SUMMARY JUDGMENT ON THE ISSUE OF LIABILITY

I. INTRODUCTION

Plaintiff, STATE OF ARIZONA, has brought this action on its own behalf and as *parens patriae* on behalf of the citizens of Arizona for injunctive and declaratory relief from defendants' continuing violations of the antitrust laws. The undisputed facts in this matter establish that defendants' ongoing activities constitute *per se* violations of section 1 of the Sherman Act, 15 U.S.C. § 1, and the Uniform State Antitrust Act, Ariz. Rev. State. Ann. § 44-1402. Plaintiff therefore requests that the Court enter partial summary judgment in its favor and against defendants on the issue of liability.

There is no dispute that the defendant foundations are combinations of doctors which formulate, adopt and circulate comprehensive schedules of fees for services, goods and products sold by doctors. More than 1,000 doctors in Maricopa County and more than 400 doctors in Pima County have signed agreements to abide by the foundation fee schedules. It is also undisputed that during the four year period prior to the filing of the complaint in this matter, increases in the foundation fee schedules were periodically adopted by mail ballot of the foundation membership, and that such price increases typically followed price surveys and consultations with defendants' members and various doctors' associations regarding desirable relative value

schedules and conversion factors. Defendants do not and cannot dispute that they and their members have used and continue to use agreed-upon fee schedules to set prices for services, goods and products sold by doctors in Arizona.

From their inception, the foundations have functioned as arms of the defendant medical societies. It is not disputed that the societies created the foundations for the purpose of promoting the interests of "fee-for-service medicine,"[13] and that the foundations' pricing agreements have been formulated and adopted with the knowledge and approval of the societies. Indeed, the foundations' By-laws[14] have granted member doctors only the limited right to vote on uniform, average or median fee schedules, while vesting the general voting power exclusively in the members of the societies' elected boards of directors.

Defendants' conspiracy has been effectuated through agreements between the foundations and certain health insurers which underwrite foundation plans. Those agreements require the insurers to pay doctors for covered services to foundation policyholders at the prices fixed by foundation fee schedules and to provide coverage for the wide range of doctor's services defined in defendants' minimum standards for foundation plans. Under those agreements, defendants' members may submit claims which foundation policyholders have assigned to them in advance directly to the foundations for payment. The review and

[13] "Fee-for-service medicine" refers to the sale of doctor's services in return for fees based upon the services rendered, as opposed to work performed for a salary or for capitation payments.

[14] Since this action was filed, the By-laws of the Pima Foundation for Medical Care have been amended to sever the relationship between that foundation and the Pima County Medical Society. Gerdenics Deposition, pp. 70-72. A stipulated Judgment against the Pima County Medical Society was filed on November 17, 1978. The Maricopa County Medical Society remains a defendant herein.

payment of claims on foundation plans is performed by foundation members. Thus, the foundations have eliminated third party review of doctors' bills under foundation plans.

Defendants' fee schedules come in two parts: the relative value schedule and the "foundation fee schedule" of unit conversion factors. A relative value schedule is a compilation of doctor's services which assigns a relative unit value to each service listed. A unit conversion factor is a number or dollar figure used to multiply the unit value for any doctor's service into a dollar figure payable for that service. The foundation fee schedule provides unit conversion factors for six categories of relative values. By multiplying the unit value for each procedure by the foundation conversion factor in that category, doctors can determine the price approved by the foundation membership for each procedure found in the relative value schedule.

By agreement, defendants use certain relative value schedules which were originally developed by the California Medical Association, American Society of Anesthesiologists and American College of Radiology. Defendants have maintained and updated those relative value schedules by agreeing upon relative values for new and additional procedures, and by providing instructions for uniform use of those schedules by their members. At the request of various doctors' associations, defendants have adjusted the prices for some procedures by increasing the unit values for those procedures. In addition, the Maricopa Foundation has devoted considerable effort to the preparation of a special relative value schedule for Arizona doctors.

In a deposition taken on November 14, 1978, the designee of the Pima Foundation for Medical Care, Ms. Mary Gerdenics, explained the way in which agreed-upon relative value schedules and conversion factors are used by defendants and their members. Deposition of Pima Foundation for Medical Care by its designee Mary Gerdenics, taken November 14, 1978, filed November 20, 1978 (hereinafter

"Gerdenics Deposition") pp. 24-26, 41-49. Referring to the Pima Foundation's edition of the California Relative Value Schedule (Gerdenics Deposition Exhibit 18), the foundation's representative related the method by which uniform prices are computed with foundation fee schedules:

> A. Well, say an office visit would have a 1.0 units assigned; you would multiply your 1.0 units times your medicine schedule to come up with what you would pay for that particular procedure.
>
> Q. So, in other words, you would multiply the dollar amount in the appropriate category times the relative value accorded a specific procedure?
>
> A. Yes, uh-huh.
>
> Q. In order to determine a price, then, with the Foundation fee schedule, it is necessary to use a relative value schedule?
>
> A. Yes, uh-huh.
>
> Q. And conversely, the relative value schedule is part of the fee schedule of the Pima Foundation?
>
> A. Yes, uh-huh.

Gerdenics Deposition, pp. 25-26.

Later in the same deposition, the witness confirmed that increasing the unit value assigned to a procedure in the relative value schedule would increase the price charged for that procedure, whereas an increase in the foundation's conversion factor would raise prices across the board in the increased category.

> Q. If you would be kind enough to clarify for me the manner in which this is used.
>
> At Page Nine, taking a simple value, Procedure 9004 under medicine is labeled as: Follow-up Office Visit, Routine, and has a unit value of one; is that correct?

A. Yes, uh-huh.

Q. If the conversion factor for medicine is ten, then the fee charged for a routine follow-up visit would be ten?

A. Yes, uh-huh.

Q. And if the conversion factor for medicine is 12, then the fee charged for a routine follow-up office visit is 12?

A. Yes.

Q. If the value of Procedure 9004 labeled: Follow-up Office Visit, Routine, were increased to 1.5, then the price of that office visit would be increased by 50 percent; is that correct?

A. Yes, uh-huh.

Just to clarify again, then, if the unit value of one procedure is increased, the price is increased only for that one procedure; is that right?

A. Yes, if you only increase one.

Q. Okay, but if the conversion factor is increased, it raises the prices of all the procedures within the category of that conversion factor?

A. Yes.

Thus, the testimony of the foundation's own representative establishes that defendants' use of agreed-upon relative value schedules and conversion factors results in uniform pricing and uniform step increases in doctors' prices. This type of pricing agreement is, as a matter of law, a *per se* violation of section 1 of the Sherman Act and the Uniform State Antitrust Act.

II. ARGUMENT

A. Defendants' Use of Agreed-Upon Relative Value Schedules and Conversion Factors Constitutes a Per Se Violation of Section 1 of the Sherman Act.

Under section 1 of the Sherman Act, 15 U.S.C. § 1, any combination which tampers with price structures is unlawful on its face. *United States v. Socony-Vacuum Oil Co.*, 310 U.S. 150, 221, 60 S.Ct. 811, 843 (1940). Because any combination or agreement which restrains price competition undermines the strong public policy favoring a competitive marketplace, the Supreme Court has consistently ruled that *any* agreement to fix, raise, maintain or stabilize prices is *per se* unlawful, even if the price fixed is purported to be reasonable.

> The power to fix prices whether unreasonably exercised or not involves power to control the market and to fix arbitrary and unreasonable prices. The reasonable price fixed today may through economic and business changes become the unreasonable price of tomorrow. *United States v. Trenton Potteries Co.*, 273 U.S. 392 397, 47 S.Ct. 377, 379 (1927). *See Also United States v. National Ass'n of Real Estate Bds.*, 339 U.S. 485, 488-489, 70 S.Ct. 711, 714 (1950). *Northern California Pharmaceutical Ass'n v. United States*, 306 F.2d 379, 385 (9th Cir.), *cert. denied*, 371 U.S. 862 (1962).

The undisputed facts in this case clearly establish that defendant foundations are combinations which tamper unlawfully with price structures. The very forms on which doctors apply for foundation membership and approve increases in foundation conversion factors are express agreements to fix prices. The foundation conversion factors establish an agreed-upon level for doctors' prices and provide a key for computing uniform prices for every procedure listed in the relative value schedules used by defendants. It makes no difference that defendants call this agreed-upon price level a "maximum" level. The Supreme

Court has clearly established that maximum price agreements are just as *per se* unlawful as other price agreements, since the fixing of maximum prices poses the same unreasonable restraint on competition as the fixing of minimum prices. Because agreements among competitors to fix maximum prices, "..... no less than those to fix minimum prices, cripple the freedom of traders and thereby restrain their ability to sell in accordance with their own judgment [,]" the Supreme Court has consistently held maximum price agreements to be *per se* unlawful under section 1 of the Sherman Act. *Kiefer-Stewart Co. v. Joseph E. Seagram and Sons, Inc.*, 340 U.S. 211, 213, 71 S.Ct. 259, 260 (1951). *Accord, Albrecht v. Herold Co.*, 390 U.S. 145, 88 S.Ct. 869 (1968); *United States v. McKesson & Robbins*, 351 U.S. 305, 76 S.Ct. 937 (1956).

The Supreme Court's recent decision in *National Society of Professional Engineers v. United States*, _____ U.S. _____, 98 S.Ct. 1355, 1365-1366 (1978); clarifies the legal standard applicable to defendants' conduct. In *Professional Engineers*, the Court was presented with a professional society's "ethical rule" against competitive bidding. The defendant society had argued through protracted litigation that its ban on competitive bidding was justified because price competition by engineers could be detrimental to the public welfare. Characterizing defendants' arguments as a fundamental misunderstanding of antitrust analysis, the Supreme Court ruled that the society's ban on competitive bidding was unlawful on its face because, while it was not price fixing as such, "no elaborate industry analysis [was] required to demonstrate the anticompetitive character of such an agreement." *Id.*, 98 S.Ct. at 1365. Since the ban "impede[d] the ordinary give and take of the marketplace,' and substantially deprive[d] customers of the 'ability to utilize and compare prices in selecting engineering services[,]' " the Court held that the agreement on its face restrained trade within the meaning of section 1 of the

Sherman Act. *Id.*, 98 S.Ct. at 1365-1366. Under this legal standard, the price agreements and price schedules of the defendant foundations are clearly *per se* violations of section 1 of the Sherman Act.

Indeed, the agreed-upon use of relative value schedules alone constitutes a *per se* violation of the Sherman Act under the *Professional Engineers* standard. No elaborate industry analysis is required to demonstrate the anticompetitive impact of defendants' use of relative value schedules as uniform pricing manuals. The anticompetitive effect of that practice is amply demonstrated by defendants' price surveys and ballots on price increases, for only the collective use of the relative value schedule makes it possible for defendants to fix the prices of thousands of doctor's services by circulating six numbers on a postcard. Used as a uniform price key by defendants, relative value schedules serve only to relieve the individual doctor of the burden of individual pricing decisions. The use of such pricing manuals and formulas has consistently been held to violate the Sherman Act. *E.G., United States v. Container Corporation of America*, 393 U.S. 333, 87 S.Ct 510 (1969); *Morton Salt Co. v. United States*, 235 F.2d 573 (10th Cir. 1956); *Food & Grocery Bureau of Southern California v. United States*, 139 F.2d 973 (9th Cir. 1943). In recent years, numerous consent judgments have been entered enjoining doctors' associations from using relative value schedules. *E.g., United States v. Illinois Podiatry Society, Inc.*, 1977-2 CCH Trade Cas. ¶ 61,767, at 73,170 (N.D. Ill., 12/6/77; *Federal Trade Commission v. Minnesota Medical Ass'n.*, FTC File No. 771 0028, 3 CCH Trade Reg. Rep. ¶21,236, at 21,186 (4/20/77); *Federal Trade Commission v. American College of Radiology*, FTC File No. 761 0059, 3 CCH Trade Reg. Rep. ¶21,236, at 21,134 (11/17/76); *Federal Trade Commission v. American College of Obstetricians and Gynecologists*, FTC File No. 761 0043, 3 CCH Trade Reg. Rep. ¶21,171, at 21,082 (7/17/76); *Federal Trade Commission v. American Academy of Orthopedic Surgeons*, FTC File No. 761 0058, 3 CCH Trade Reg. Rep. ¶21,171, at

21,082 (7/16/76). Nevertheless, defendants have not only continued to use agreed-upon relative value schedules, but have proceeded to update and maintain in Arizona fee schedules which are subject to consent decrees elsewhere and to develop a new relative value schedule for Arizona doctors. This flagrant violation of the antitrust laws in the face of repeated warnings of illegality cannot be justified or condoned under the rule of *Professional Engineers.*)

Furthermore, the price agreements and consultations regarding desirable relative values and conversion factors which have typically preceded increases in the foundation fee schedules also violate the Sherman Act, since they impede the ordinary give and take of the marketplace and deprive persons seeking medical care of the benefits of price competition. *United States v. Container Corporation of America,* 393 U.S. 333, 89 S.Ct. 510 (1969); *United States v. Utah Pharmaceutical Ass'n.,* 201 F. Supp. 29, 34-35 (D. Utah), *aff'd per curiam,* 371 U.S. 24, 83 S.Ct. 119 (1962); *Phelps Dodge Refining Corp. v. Federal Trade Commission,* 139 F.2d 393 (2d Cir. 1943). In *United States v. Container Corporation of America, supra,* the Supreme Court held that reciprocal exchanges of price information violated the Sherman Act even when no agreement had been made to adhere to any specific price, because each defendant had a manual with which it could compute its competitor's prices. Thus, defendants' regular price surveys, consultations and agreements with foundation members and numerous doctors' associations regarding their collective use of agreed-upon relative value schedules and conversion factors are clearly in violation of the Sherman Act.

The Supreme Court has made it unmistakably clear that members of the so-called "learned professions" are subject to the same antitrust scrutiny as anyone else. *National Society of Professional Engineers v. United States,* _____ U.S. _____, 98 S.Ct. 1355,1367 (1978); *Goldfarb v. Virginia State Bar,* 421 U.S. 773, 787-88, 95 S.Ct. 2004, 2013-

14 1975). The rule of law applicable to professional group activities which impede the setting of price by free market forces was restated in the clearest possible terms in *Professional Engineers:*

> Price is the "central nervous system of the economy," and an agreement that "interfere[s] with the setting of price by free market forces" is illegal on its face. 98 S.Ct. at 1365 (Citations omitted).

Defendants' undisputed use of agreed-upon relative value schedules and unit conversion factors unquestionably interferes with the setting of price by free market forces. Under the holding of *Professional Engineers*, their ongoing conspiracy to fix and stabilize the prices charged by doctors in the State of Arizona is unlawful on its face.

B. Defendants' Use of Agreed-Upon Relative Value Schedules and Conversion Factors Constitutes a Per Se Violation of the Uniform State Antitrust Act.

Arizona Revised Statutes Annotated § 44-1402 prohibits any "contract, combination or conspiracy between two or more persons in restraint of, or to monopolize, trade or commerce," any part which is within the State of Arizona. The Arizona Legislature specifically provided in Arizona Revised Statutes Annotated § 44-1412 that federal case law interpreting the federal antitrust statutes should be used as a guide in construing the Uniform State Antitrust Act, so that a consistent body of case law will be developed under the Uniform Act. Thus, the standards enunciated by the Supreme Court in applying the Sherman Act also apply to defendants' conduct under the Uniform State Antitrust Act. *Cf., Sherman v. Transamerica Title Ins. Co.*, 580 P.2d 729 (Ariz. App. 1978). Under those standards, defendants' actions are *per se* violations of the Uniform State Antitrust Act as well as the Sherman Act. Indeed, the strong public interest favoring a competitive marketplace which has been

enunciated by the federal courts is underscored in the State of Arizona by the constitutional protection against price-fixing and other restraints of trade which has been provided in the Arizona Constitution. Ariz. Const. art. 14 § 15.

C. Even If Defendants' Conduct Were Subject To Rule of Reason Analysis, It Would Clearly Be In Violation of Section 1 of the Sherman Act and the Uniform State Antitrust Act.

In the *Professional Engineers* decision the Supreme Court determined that the defendant society's arguments to the effect that competition by professionals was not in the public interest had been based upon "a fundamental misunderstanding of the Rule of Reason." 98 S.Ct. at 1360. The Court ruled that arguments about the merits of competition in a profession, *id.* at 1367-1368, or the purported benefits of monopolistic arrangements, *id.* at 1364, were simply not cognizable under the Sherman Act. Clarifying the legal standard to be applied under the Rule of Reason, the Court said:

> [T]he inquiry mandated by the Rule of Reason is whether the challenged agreement is one that promotes competition or one that suppresses competition. *Id.* at 1365.

While this legal standard is more lenient than the *per se* rule which applies to price-fixing and other agreements having clear anticompetitive impact, it would still mandate a determination that defendants' use of agreed-upon price schedules is in violation of section 1 of the Sherman Act and the Uniform State Antitrust Act.

III. CONCLUSION

The Supreme Court's ruling in *National Society of Professional Engineers v. United States* is dispositive of this case. Defendants' undisputed use of agreed-upon relative value schedules and conversion factors to set doctors' prices is, to a far greater extent than a professional rule against competitive bidding, an agreement which " 'impedes the

ordinary give and take of the marketplace,' and substantially deprives customers of the 'ability to utilize and compare prices in selecting [professional] services.'" 98 S.Ct. at 1365-1366. Under the clear standards enunciated in *Professional Engineers,* the horizontal pricing agreements among doctors which the undisputed facts in this case establish are on their face restraints of trade within the meaning of section 1 of the Sherman Act and the Uniform State Antitrust Act. Although these price-fixing agreements fall within the *per se* rule, they would also be deemed unlawful under the Rule of Reason standard enunciated by the Supreme Court, because they have suppressed price competition by establishing and maintaining a uniform pricing system for Arizona doctors. Since there is no dispute on any material fact and defendants can raise no defense for their conduct that is cognizable under the Sherman Act, plaintiff is entitled to the entry of partial summary judgment in its favor and against defendants that defendants' actions are in violation of the Sherman Act and the Uniform State Antitrust Act. *International Salt Co. v. United States,* 332 U.S. 392, 68 S.Ct. 12 (1947).

DATED this 20th day of November, 1978.

(Signatures omitted in printing.)

Filed - DEC 7, 1978
W. J. Furstenau, Clerk
U. S. District Court
For The District of Arizona

RESPONSE TO PLAINTIFF'S MOTION FOR PARTIAL SUMMARY JUDGMENT ON THE ISSUE OF LIABILITY

The defendant, Pima Foundation for Medical Care, hereby enters its opposition to the plaintiff's Motion for Partial Summary Judgment on the issue of liability and adopts as its memorandum in support thereof its memorandum heretofore filed in opposition to Plaintiff's Motion for Partial Summary Judgment on the Issue of Subject Matter Jurisdiction.

The essentials of this defendant's opposition to both Motions are contained in that memorandum, which is adopted for this purpose by this reference.

Respectfully submitted,

(Signature omitted in printing.)

Filed - DEC 7, 1978
W. J. Furstenau, Clerk
U. S. District Court
For The District of Arizona

(Caption omitted in printing.)

OPPOSITION TO PLAINTIFF'S MOTION FOR PARTIAL SUMMARY JUDGMENT ON THE ISSUE OF SUBJECT MATTER JURISDICTION

The defendant Pima Foundation for Medical Care responds to the Attorney General's Motions for Summary Judgment as follows:

The Attorney General of the State of Arizona has alleged that defendant, Pima Foundation for Medical Care has violated federal antitrust law. The Attorney General does *not* allege, nor is there evidence tending to prove, that the Pima Foundation has imposed mandatory uniform fee schedules on doctors who practice within Pima County. Hence, this case does not fall within the rule announced in *Goldfarb v. Virginia State Bar*, 421 U.S. 773, 95 S.Ct. 2004 (1975). That Court observed:

> "A purely advisory fee schedule issued to provide guidelines, or an exchange of price information without a showing of actual restraint on trade, would present us with a different question." (Citations omitted.) 421 U.S., at p. 781.

The Sherman Act does not prohibit the gathering of average cost information within a trade or profession, even though some uniformity of pricing may result. *Cement Mfgrs. Protective Association v. United States*, 268 U.S. 588, 45 S.Ct. 586 (1924); *Maple Flooring Mfg. Association v. United States*, 268 U.S. 563, 45 S.Ct. 586 (1924).

Plaintiff Mr. Goldfarb was able to prove that the Bar Association's minimum fee schedule was more than an exchange of average price information. It was mandatory, given that any attorney who habitually charged less than the minimum schedule was presumed to be "guilty of misconduct." (Id. at p. 778). He also demonstrated actual

"restraint on trade," in that all of the 37 attorneys that he contacted in Fairfax County, Virginia, refused to examine the title for less than the local fee schedule.

In contrast, the Attorney General has not alleged that the Pima Foundation has imposed mandatory fee schedules on doctors. Nor has the Attorney General introduced any evidence that the Foundation has the power to set uniform fees for all doctors in the County, or that it has attempted to do so.

Rather, the Attorney General alleges that the Pima Foundation has fixed uniform fees with respect to three health insurance policies written by three major insurance carriers. Thus, the essence of the Complaint is that this defendant, *through the medium of three independent health insurance carriers,* has conspired to fix prices for covered health services. The heart of the Attorney General's Complaint, then, is that this defendant has conspired to set the rates for *health insurance payments* to Pima County doctors. Since health insurance is substantial business in this State and throughout the United States, the Attorney General asserts that this alleged local price fixing of *health insurance* payments ripples into the health industry generally and across state lines.

However, even if the Attorney General could prove the jurisdictional and substantive claims relevant to federal antitrust violation, the very nature of the Complaint and the facts of this case fall within the "business of insurance" exemption. The controlling statue, known as the McCarran Act, provides that the Sherman, Clayton and Federal Trade Commission Acts:

> "... shall be applicable to the business of insurance to the extent that such business is not regulated by State law." 15 U.S.C. §1012(b).

There can be no question that the Pima Foundation is "regulated by State law." as evidenced by the attached letter from the State of Arizona Department of Insurance. (See Exhibit "A") This letter, dated October 30, 1978, is addressed to the Pima Foundation for Medicare (sic) Care and states the following:

> "It has come to the attention of this Department that the functions your organization perform are those of an Insurance Administrator as defined under the Arizona Revised Statute Section 20-485 (et seq). You are therefore required to comply with this law by obtaining from this Department a Certificate of Registration. For your convenience we are enclosing the necessary forms."

A.R.S. § 20-485 is applicable to the Pima Foundation in that it processes claims for health insurance, for which it receives a six per cent management fee. (See the attached affidavit of Mr. Finley, Exhibit "B.") The Foundation does not collect premiums.

Thus, the Pima Foundation falls squarely within the statutory language as an "Insurance Administrator" in that it processes claims for payment and sets maximum rates for various categories of covered health services.

The Attorney General ignores the fact that the Foundation-approved health insurance plans do not require participation of all doctors, nor does it preclude any doctors from payment for services rendered to Foundation-approved policyholders.

Policyholders are not required to see only those doctors who are members of the Foundation. It may be to the advantage of the policyholder to see a Foundation doctor, who has agreed that his charges will not exceed the *ceiling* rates established by the Foundation. On the other hand, if the policy-holder receives medical service from a doctor who is

not a member of the Foundation, the Foundation will pay the same amount as to a Foundation doctor—but the policy holder must be responsible for any excess charge assessed by the non-Foundation doctor. (See Exhibit "B.")

Thus, the Foundation-approved plans represent the effort of the private medical community to control rising health costs. It does this by setting maximum rates which *the Foundation* will pay to given specialists for given medical tasks. It in no way interferes with the choice of patients or doctors.

If a policyholder happens to be traveling out-of-state and has a need for health care, the Foundation will reimburse the out-of-state doctor at the same rates as a Foundation doctor. However, the policyholder is responsible to that non-Foundation doctor for any part of his charge which exceeds the Foundation maximum. The number of such out-of-state payments from the Pima Foundation is minimal. All of the doctors and all of the policyholders in the three Pima Foundation-sponsored plans are residents of Pima County. (See Exhibit "B.") This minimal amount of out-of-state payments is insufficient to invoke Federal jurisdiction. The United States Supreme Court disposed of the same question in *Oregon State Medical Society, supra;*

> "... The Government did show that Oregon Physicians Service made a number of payments to out-of-state doctors and hospitals, presumably for treatment of policyholders who happened to remove or temporarily be away from Oregon when need for service arose. These were, however, few, sporadic and incidental." (Id. at pp. 338-339.)

Thus, the Foundation sponsorship of health plans underwritten by three private carriers represents *new competition* in the local health insurance market. As in

Oregon State Medical Society, supra, the Foundation's entry into the field of prepaid medical care makes it another one of several "competitors in the field." (Id., at pp. 334-335.)

It is important to note that *Oregon State Medical Society* is not inconsistent with *Goldfarb,* in that the latter involved the setting of minimum fees for all attorneys within the State of Virginia. Furthermore, *Goldfarb* involved examination of titles of property prior to sale, a mandatory function with obvious interstate ramifications as to foreign buyers and lenders.

In contrast, *Oregon State Medical Society* involved a group of doctors who associated for the purpose of entering the prepaid medical field. As such, their prepaid plans tended to increase competition among existing health insurance policies. In so doing, these prepaid medical plans did not interfere in the choices made by doctors and patients.

Mr. Goldfarb had no choice but to pay the mandatory minimum fee if he wanted to buy property, whereas the policyholders in *Oregon State Medical Society* and in the present case have the added choice of another competitor health plan.

BREADTH OF THE "BUSINESS OF INSURANCE" EXEMPTION

The "business of insurance" exemption from federal antitrust jurisdiction is one of considerable breadth, and is not affected by whether or not there is a conflict between Federal and State regulation on material issues. *Proctor v. State Farm Mutual Auto Ins. Co.,* 561 F.2d 262 (D.C., 1977).

The "business of insurance" exemption is effective even if the State is lax in regulating those engaged in any of the many facets of insurance. The mere existence of State regulatory machinery is all that is required for the McCarran Act exemption to come into play. *Proctor, supra; Ohio AFL-CIO v. Insurance Rating Board,* 451 F.2d 1178 (6th

Cir., 1971), cert. den. 409 U.S. 917. The breadth of the exemption was discussed in *Dexter v. Equitable Life Assurance Society of U.S.*, 527 F.2d 233 (2d Cir., 1975) in the following terms:

> "The McCarran-Ferguson Act clearly contemplates that where a state undertakes to regulate the business of insurance, it has the power to permit practices which would otherwise violate federal antitrust laws; if the exemption is only to apply when state law squarely prohibits all acts which would, absent the exemption, violate the antitrust laws, the state regulation which the McCarran-Ferguson Act aims to foster, 15 U.S.C., §§ 1011, 1012(a), would be a nullity." (Citations omitted.) 527 F.2d, at p. 236.

Prior to 1943, the common law held that interstate insurance transactions were not "interstate commerce." However, the United States Supreme court re-read the existing statutory definition of "in commerce" jurisdiction and found that interstate insurance transactions were "in commerce." *United States v. South-Eastern Underwriters Ass'n.*, 322 U.S. 533, 64 S.Ct. 1162 (1943).

In response to the holding of *South-Eastern*, Congress added a statutory exception to the "in commerce" jurisdiction as regards state-regulated insurance activity. The McCarran Act, 15 U.S.C., §1011, et seq., reinstated the common law principle that state regulation of the "business of insurance" should generally be unhampered by federal regulation of "interstate commerce." This statute is in harmony with the recent holding in *National League of Cities v. Usery*, 426 U.S. 833, 96 S. Ct. 2465 (1976), which narrowed the reach of "in commerce"jurisdiction where direct state activity was involved. As noted by the Attorney General in the present case, congressional determination of

an issue (such as the exemption of the "business of insurance" from federal antitrust jurisdiction) "merits great deference in this forum." (See the Attorney General's Motion for Partial Summary Judgment, p. 3, lines 23-26.)

The present case is similar to *Proctor, supra,* which was an antitrust action brought by four automobile repair shops against five insurance carriers. The complaint alleged that the five insurance carriers conspired to fix the prices of claims settlements, and that such price fixing was based upon standardized labor rates. The plaintiffs also alleged that the defendants furthered a group boycott favoring certain auto repair shops while disfavoring plaintiffs' repair shops. The favored repair shops complied with the carrier-imposed formula for computation of claims.

The United States District Court granted summary judgment to the defendants on the ground that the conduct of defendants fell within the McCarran Act "business of insurance" exemption. The Court of Appeals affirmed, citing the following language of the District Court with approval:

> "[The] activities complained of in this suit have a vital impact on rate-making and must, of necessity, be included within the term 'business of insurance.' . . . The 'business of insurance' can touch relationships between insurance companies and non-policyholders such as automobile repair shops *when such relationships are closely connected with the insurer-insured relationship through the profound effect of the costs of damage claims in the rate making structure."* Emphasis in Court of Appeals' Opinion, 561, F.2d, at p. 269.)

The plaintiffs argued that the "core" of their case was the horizontal agreement to pay an insured's claim on the basis of the standard formula, based upon standardized labor rates. The District Court and the Court of Appeals found, as a matter of law, that this "core" of defendant's activity fell squarely within the "business of insurance" exemption. (Id. at p. 267.)

The principal difference between *Proctor* and the present case is that the former involved the repair of automobiles whereas the latter involves the diagnosis and treatment of human ailments. Both plaintiffs have alleged a horizontal price-fixing conspiracy, with the standard rate based upon uniform labor rates. In the present case, the uniform maximum fee schedule is drawn in part from a physician's Relative Value Schedule. (See Exhibit "B.")

The relationship of the insurer-repair shop in *Proctor* is analgous to the relationship of the Foundation-doctor in this case. Both relationships are directly connected" ... through the profound effect of costs of damage claims in the rate making structure." (Id., at p. 269)

To similar effect was the facts and holding in *Manasen v. California Dental Services*, 424 F. Supp. 657 (1976). In that case, a nonprofit corporation was in the business of operating prepaid dental care plans. This corporation actually underwrote the actuarial risk that the premium payments would be sufficient to defray the cost of services.

The corporation used the same formulas to calculate premiums as the health insurance carriers used. The United States District Court found that this corporation was engaged in the "business of insurance" and was therefore exempt from federal antitrust jurisdiction.

The case law is replete with many other examples of different kinds of insurance activity falling within the McCarran Act exemption, e.g., *Prudential Insurance Co. v. Benjamin*, 328 U.S. 408, 415-418, 66 S.Ct. 1142; *North Little Rock Transp. Co., Inc. v. Casualty Reciprocal Exchange*, 181 F.2d 174 (5th Cir., 1950); *Lawyers Title Company of Missouri v. St. Paul Title Insurance Corporation*, 526 F.2d 795 (8th Cir., 1975).

This is not to say that the "business of insurance" exemption will protect an antitrust violator where the connection between the violator's conduct and the "business of insurance" is superseded by a dominant federal

policy. See *SEC v. National Securities, Inc.*, 393 U.S. 453, 89 S.Ct. 564 (1969) (an insurance company's relationship to its stockholders is governed by SEC regulations, even though the company is in the "business of insurance").

Furthermore, the "business of insurance" exemption will not apply where the plaintiff can prove "boycott," "coercion" or "intimidation." See *Frankford Hospital v. Blue Cross of Greater Philadelphia*, 554 F.2d 1253 (3d Cir., 1977); *Travelers Insurance Co. v. Blue Cross*, 481 F.2d 80 (3d Cir., 1973); *Doctor's Inc. v. Blue Cross*, 557 F.2d 1001 (3d Cir., 1976).

One example of a "boycott" case is *Royal Drug Co. v. Group Life & Health Ins. Co.*, 556 F.2d 1375 (5th Cir., 1977), which is distinguishable from the present case. In that case, the insurer essentially promulgated a list of "approved" pharmacists which policyholders were to patronize for their prescription drug needs. The insurer reimbursed these "approved" pharmacists at a higher rate than the rate for "non-approved" pharmacists. This discrimination tended to operate as a boycott against the "non-approved" pharmacists, and hence was outside the legitimate "business of insurance" exemption.

In the present case, the Foundation-approved health insurance plans do not have an "approved" list of doctors, pharmacists or anything else. The Foundation-approved plans pay the same amounts up to a maximum for comparable service or drugs to any doctor, regardless of whether or not he is a Foundation member. The same is true of reimbursement to pharmacists: All are treated equally. Hence, the facts of this case do not fall within the *Royal Drug Co.* rule for "boycott," "coercion" or "intimidation." (See Exhibit "B")

In summary, the Pima Foundation is engaged in the "business of insurance" and is regulated by the State Department of Insurance, by their own admission (Exhibit "A"). Therefore, the McCarran Act eliminates federal antitrust jurisdiction. *Proctor, Ohio AFL-CIO, Dexter, Mana-*

sen, Oregon State Medical Society, Benjamin, North Little Rock Transp. Co., Lawyers Title Company of Missouri, supra.

NO "CONDUCT IN COMMERCE" OR "AFFECTING COMMERCE"

The Attorney General has gone to great lengths to introduce evidence that the health care industry is sizeable and that many of the transactions cross state lines. (See the Statement of Undisputed Facts attached to Plaintiff's Motion for Partial Summary Judgment.) Defendant Pima Foundation for Medical Care does not dispute the size and extent of the national health care industry. However, these facts are of no legal significance with respect to the issue of federal subject matter jurisdiction over these defendants.

The Attorney General's position is in harmony with *United States v. South-Eastern Underwriters Ass'n.*, 322 U.S. 533, 64 S.Ct. 1162 (1943). As noted previously, that case changed the common law concept that the "business of insurance" was peculiarly a state-regulated activity. However, shortly after the *South-Eastern* decision, Congress changed the statutory jurisdictional rules with the McCarran Act and reinstated the "business of insurance" exemption from federal antitrust jurisdiction. The United States Supreme Court has had numerous opportunities to overturn the McCarran Act in the past three decades, but has not done so. The only possible conclusion is that the "business of insurance" exemption is still viable.

These defendants have shown that their conduct falls within the "business of insurance" exemption as interpreted by the Courts. See *Proctor, Ohio AFL-CIO, Dexter, Manasen, Oregon State Medical Society, Benjamin, North Little Rock Transp. Co., Lawyers Title Company of Missouri, supra.* Furthermore, the Attorney General's evidence contains not even the suggestion that these defendants entered into any "boycott," coercion" or "intimidation."

Rather, the evidence shows that the State of Arizona Department of Insurance considers the Foundation an "Insurance Administrator" under relevant statutes (See Exhibit "A").

However, even if the State did not regulate the "business of insurance," or even if the conduct complained of was not within the McCarran Act exemption, the Attorney General has still failed to show that these defendants are either "in commerce" or that they have had an "effect on commerce." *Hospital Building Co. v. Trustees of Rex Hospital*, 425 U.S. 738, 96 S.Ct. 1848 (1976); *Gulf Oil Corp. v. Copp Paving Co.*, 419 U.S. 186, 95 S.Ct. 392 (1974).

Much of the Attorney General's evidence as to "in commerce" or "effect on commerce" relates to the conduct of individual doctors, hospitals and pharmacists. No one can deny that these providers of health care service and products do make purchases in interstate commerce. However, the Attorney General is not seeking injunctive and declaratory relief against them in their individual capacities. The Attorney General has named as defendants the Pima County Medical Society, the Pima Foundation for Medical Care, and two counterpart entities in Maricopa County.

The only relevant evidence or discussion has to do with acts done by the Foundation as an individual entity, not by members of organizations acting in their individual capacities. The fact that individual members of an organization engage "in commerce" does not necessarily mean that the organization also engages "in commerce." *Page v. Work*, 290 F.2d 323, 328 (5th Cir., 1961).

The Attorney General also suggests that federal "presence" in the health care industry automatically means that any provider of health care service must also be "in commerce." (See Memorandum of Law In Support of Plaintiff's Motion for Partial Summary Judgment, pp. 3-4) If this theory were correct, the "in commerce" clause would not

only be broadly construed, it would be unbounded. There is federal "presence" in almost every sphere of legal activity, to greater or lesser extent. However, federal "presence" does not equate with "in comme. ·e" jurisdiction.

A similar argument was pressed by the unsuccessful plaintiff in *Copp Paving, supra.* Defendants *Gulf Oil, Union Oil* and others were heavily engaged in producing liquid petroleum for the Los Angeles and Orange County highway construction markets. A substantial portion of their product was used in the construction of the interstate highway system in the Los Angeles area. The Court noted that Congress had passed the Federal Aid Highway Act, 23 U.S.C., §101, et seq., and specifically stated that interstate highways were critical to the national economy.

In addition, there was case law holding that the interstate highways were instrumentalities of commerce, and that employees engaged in the "production of goods for commerce" were within the Fair Labor Standards Act. *Allstate Construction Co. v. Durkin,* 345 U.S. 13, 73 S.Ct. 565 (1953). Notwithstanding these statutes and decisions, the Court found:

> "... No intention to apply the full range of antitrust laws to persons who, as part of their local business, supply materials used in construction of local segments of interstate roads." (419 U.S., at p. 197)

The practice of the healing arts is local in character. *Spears Free Clinic and Hospital for Poor Children v. Cleere,* 197 F.2d 125, 126 (10th Cir., 1952). The fact that the Foundation approves a minimal amount of payments to out-of-state doctors, who treat Foundation policyholders away from Arizona when services are needed, is insufficient to either be "in commerce" or "affect commerce." *Oregon State Medical Society,* 343 U.S. 326, 338-339, 72 S.Ct. 690 (1952).

or is it sufficient to note that Foundation policyholders premiums to out-of-state insurance carriers, or that ı carriers reimburse the Foundation based on 6% of .e premiums. Both Gulf Oil Company and Union Oil ıpany had interstate dealings with their 100% owned ıidiaries who were charged with price-fixing. The *Copp ing* Court rejected the theory that interstate companies ion Oil and Gulf Oil) were automatically "in commerce" n their 100% owned subsidiaries supplied products for l segments of interstate highways. The Court gave the ›wing reason:

The chain of connection has no logical endpoint. The niverse of arguably included activities would be broad nd its limits nebulous in the extreme." (Id., at p. 198)

'he position taken by the Attorney-General in the pre- : case presses upon the Court a chain of connection ch has "no logical endpoint." The mere "presence" of ›ral statutes in the health industry cannot automatically fer "in commerce" jurisdiction over local health provi- ; any more than federal highway statutes or labor .utes convey automatic "in commerce" jurisdiction over ion-dollar oil companies competing in sizeable local ·kets. The Court further observed:

The plaintiff must allege and prove that apparently ›cal acts in fact have adverse consequences on inter- tate markets and the interstate flow of goods in order ›o invoke federal antitrust prohibitions. See *United ›tates v. Yellow Cab Co.*" (Citations omitted) (Id., at 02)

t is undisputed that all 400 doctors in the Foundation l all 6,000 policyholders are residents of Pima County, l that the Foundation restricts its operations to Pima ınty in the State of Arizona. (See Exhibit "B.")

'he fact that some patients come from out-of-state to be ıted by doctors in Arizona is totally irrelevant to the duct of these defendants. The Foundation has no con- l over what price Foundation or non-Foundation doctors

charge non-Foundation patients. The contract between the Foundation and its member doctors is completely silent as to the member doctor's dealings with non-Foundation patients, such as tourists from another state.

This contract does fix a price limit on the doctor's charge to Foundation policyholders. (A limitation for covered charges is common in health insurance policies. Without it, health insurance carriers would be totally at the mercy of doctors and patients.) It should be pointed out that the contract does not require the doctor to charge anything at all to a Foundation policyholder. If he so desires, the doctor could treat the patient for nothing, or for less than maximum rate. The Foundation contract merely sets a maximum limit on the charge for covered services, based upon the nature of the service and the doctor's specialization.

Since the Foundation is located in Pima County, all of the member doctors are located in Pima County, and all of the policyholders reside in Pima County, it is wholly a local matter what prices are charged. Out-of-state patients are treated according to the doctor's own pricing policy, whatever that may be. The Foundation has no pricing policy for out-of-state patients or for in-state patients who are not policyholders in Foundation sponsored plans.

In jurisdictional terms, the relationship between Foundation doctors and policyholders is similar to the relationship between local taxi drivers and local residents. *United States v. Yellow Cab Co.*, 332 U.S. 218, 67 S.Ct. 1560 (1946). In that case, Chicago taxi companies held licenses which specifically restricted their service "between any two points within the corporate limits of the City." (332 U.S., at pp. 230-231) When a local passenger would leave his home, board a cab, and then travel to a city railway station to embark on interstate business, the cab ride from the passenger's home to the terminal was held to be *outside* of the stream of interstate commerce. Likewise, when a resident returned to Chicago by train, boarded a cab from the ter-

minal, and traveled to his home, that ride was also *outside* interstate commerce. The Court held that "such transportation is too unrelated to interstate commerce to constitute a part thereof within the meaning of the Sherman Act." (Id., at p. 230)

However, if an interstate passenger on a train boarded the same cab to travel the short distance between one interstate terminal to another, that trip was held to be within the stream of commerce. (Id., at p. 228)

Therefore, even though a Foundation policyholder visited a Foundation doctor before leaving the state or immediately upon returning to the state, the doctor-patient relationship would be totally based within the state.

Since the entire conduct of the Foundation is centered in its member doctors and its policyholders—all of whom are residents of Pima County—where is the adverse effect on interstate commerce that the Attorney General must prove? *Copp Paving, supra.* Given that only one percent of the population of Pima County is covered by a Foundation-sponsored health plan, any effect would be *de minimus.* The maximum rates of health care payment would certainly not interfere with interstate travel in any reasonable way. *Heart of Atlanta Motel, Inc. v. United States,* 379 U.S. 241, 85 S.Ct. 348 (1964).

The Foundation does not, as a corporate entity, purchase any drugs or medical supplies, or wield any influence on individual doctors and pharamcists as to their purchases in interstate commerce. Since the Attorney General has not named these individual doctors and pharmacists as defendants, the allegation that the Foundation "affects" commerce through purchase of such supplies is without evidentiary foundation.

LOCAL ACTIVITIES WHICH "AFFECT COMMERCE"

The Attorney General has cited a number of cases where local activity had an adverse "effect" upon interstate commerce. These cases are distinguishable from the present case.

The Attorney General repeatedly cites *Rex Hospital, supra,* for the proposition that local health care activity may have a substantial effect on interstate commerce. Before considering the factual differences between *Rex Hospital* and the present case, it should be noted that the lower Court dismissed the original complaint on the pleadings. On remand, the United States Supreme Court stated:

> "We have held that 'a complaint should not be dismissed for failure to state a claim unless it appears beyond doubt that the plaintiff can prove no set of facts in support of his claim which would entitle him to relief' . . . And in antitrust cases, where 'the proof is largely in the hands of the alleged conspirators' . . . dismissals prior to giving the plaintiff ample opportunity for discovery should be granted very sparingly . . ." (Citations omitted.) 425 U.S., at pp. 746-747.

Therefore, the Court did not rule on the factual merits of the case, but held that the complaint was sufficient under several theories to state a cause of action. (In the present case, the Attorney General has had ample opportunity for discovery and has introduced evidence.)

The plaintiff, Hospital Building Company, was a private company which desired: (1) to relocate Mary Elizabeth Hospital to a site within Raleigh, N.C., and (2) to expand its size from 49 to 140 beds. Defendant Rex Hospital, also located in Raleigh, attempted to block Hospital Building's application for a state permit to relocate and expand. After

a long delay, the permit was granted, after which Rex Hospital allegedly engaged in frivolous litigation and maliciously published adverse information about Mary Elizabeth Hospital's proposed expansion.

Thus, an existing provider of health service in the city, Rex Hospital, attempted to *completely foreclose* the efforts of a competitor from moving into the same geographical area and from thereafter tripling in size.

If Rex Hospital succeeded in foreclosing this relocation and expansion, Hospital Building Company would not have purchased as many medical supplies, borrowed as much money, or served as many patients—allegedly from out-of-state.

Since the trial court dismissed the complaint on its pleadings, Hospital Building Company had no opportunity to present admissable *evidence* as to the actual "effect" on commerce. In weighing the dismissal on the pleadings, the United States Supreme Court properly assumed that such "effect" could have been shown by the plaintiff.

Since the present proceeding is one in Summary Judgment, the Court has the benefit of the Attorney General's evidence as to "adverse effect on interstate commerce." There is no showing of interstate lending activity which has been foreclosed by defendant's conduct. Nor has the Attorney General shown how the Foundation may have adversely affected the interstate flow of drugs, medical supplies or patients.

The Foundation has done nothing to *foreclose* the health care industry in Pima County, or any part of it, nor has there been any evidence that competition has been other than benefitted by the addition of new prepaid health plans with unique controls over major expense items.

Rex Hospital did not involve the McCarran Act or the "business of insurance" exemption, nor did the competing hospitals even claim the "business of insurance" exemption.

Even if the McCarran Act was applicable, the remand of *Rex Hospital* would be fully consistent with its "boycott," "coercion" and "intimidation exceptions." Defendant Rex Hospital mounted an attempted total boycott of the proposed relocation and expansion of Mary Elizabeth Hospital, and attempted to coerce and intimidate Mary Elizabeth Hospital, its prospective patients and customers.

The Attorney General has cited other cases where local activity was held to "affect" interstate commerce. In each of these decisions, the defendants were guilty of conduct which could be equated with "boycott," "coercion" or "intimidation."

For example, *Goldfarb* involved a total boycott by the Virginia State Bar against any attorney who would charge a title examination fee lower than the Bar-approved minimum: that attorney, would be presumed to be "guilty of misconduct." The minimum fee schedule also acted to coerce property buyers, since it was virtually impossible to buy property without the title examination, and only Virginia lawyers had legal authority to do the work. *Goldfarb* did not address the McCarran Act or the "business of insurance" exemption.

The same is true of *United States v. Employing Plasterers Assoc.*, 347 U.S. 186, 74 S.Ct. 452 (1953). Chicago plastering contractors and labor unions, who controlled 60% of the plastering market in the area, combined to *prevent* out-of-state contractors from doing business in the Chicago area. The Foundation has not acted to prevent any health provider or insurer from entering the competing in the local market.

Mandeville Island Farms v. American Crystal Sugar Company, 334 U.S. 219, 68 S.Ct. 996 (1948) involved a conspiracy by local sugar refiners against local sugar beet growers. The refiners were the *only* market for the buyers, thus, the refiners were able to intimidate and coerce the growers to accept the refiners' pricing formula.

The same pattern emerged in other cases cited by the Attorney General, e.g., *DeVoto v. Pacific Fidelity Life Insurance Co.*, 516 F.2d (9th Cir., 1975) (a Transamerica loan company and a Transamerica insurance company eliminated a competitor insurance company from a sizeable portion of the California mortgage market); *Gough v. Rossmoor*, 487 F.2d 373 (9th Cir., 1973) (a Rossmoor land developer and a Rossmoor retailer of carpets and drapes combined to exclude a private retailer of furniture, carpets and drapes from a Rossmoor residential development); *Las Vegas Merchant Plumbers Ass'n. v. United States*, 210 F.2d 732 (9th Cir., 1954) (a plumbing association established a committee to allocate bids; wholesalers and laborers who did not comply were boycotted by the remainder of the association); *Boddicker v. Arizona State Dental Association*, 549 F.2d 626 (9th Cir., 1977) (the state and local dental associations coerced its member dentists to also be members of the American Dental Association, even though a dentist in Arizona could practice his profession without joining any of them).

The Foundation has done none of the things which would place them in this line of cases. The Foundation treats Foundation and non-Foundation doctors alike. All pharmacists and hospitals are treated alike.

CONCLUSION

The Sherman Act is "aimed at substance rather than form." *United States v. Yellow Cab Co.*, 332 U.S., at p. 227. Mere exchange of average price information does not run afoul of antitrust prohibitions, even if some uniformity of pricing results. *Cement Mfgrs., Maple Flooring Mfgrs., supra*. The fact that Foundation-sponsored health policies

contain *maximum* prices may appear to have the "form" of a conspiracy in restraint of trade does not mean that such a conspiracy exists in "substance."

The State of Arizona, through its Department of Insurance, has admitted that the Foundation is an "Insurance Administrator" under Arizona law. (Exhibit "A") Therefore, even if the Attorney General could prove the merits of its case, the McCarran Act "business of insurance" exemption would eliminate federal jurisdiction. 15 U.S.C., § 1012(b); *Oregon State Medical Society, Proctor, Page, Ohio AFL-CIO, Dexter, Usery, Manasen, Benjamin, North Little Rock Transp. Co., Lawyers Title Company of Missouri, supra.*

Even if the "business of insurance" ememption was inapplicable to this case, the Attorney General has failed to submit evidence that this defendant was "in commerce" or "affected commerce." *Oregon State Medical Society, Yellow Cab Co., Copp Paving Co., supra.* The 400 doctors who are members of the Foundation serve approximately 6,000 residents of Pima County, or little more than one percent of the County's population.

Communication of average price information across state lines is insufficient to create federal jurisdiction. *Cement Mfgrs., Maple Flooring Mfgrs., supra.* The transfer of funds across state lines, even between a parent corporation and its wholly-owned subsidiary, is insufficient to confer federal jurisdiction. See *Copp Paving, supra.*

There being no material issues as to the facts upon which federal jurisdiction are based, the Motions of the Attorney General should be denied, and the Complaint dismissed against this defendant, as prayed in its Answer here.

(Signatures omitted in printing.)

EXHIBIT "A" OMITTED IN PRINTING

(Caption omitted in printing.)

AFFIDAVIT

STATE OF ARIZONA } ss.
County of Pima }

THOMAS P. FINLEY, being first duly sworn, deposes and says:

1. I am the Executive Director of the Pima Foundation for Medical Care, a position which I have occupied since February, 1978. I reside at 9035 Bears Path Road in Tucson, Arizona.

2. I have personal knowledge of the day-to-day operations of the Pima Foundation for Medical Care ("Foundation"), including its dealings with the Pima County Medical Society ("Medical Society"), the State of Arizona Department of Insurance and various outside parties such as insurance brokers and carriers involved in Foundation sponsored health plans.

3. The Foundation was formed in 1971 by the Medical Society. Its primary purpose was to offer a competitive health plan to help control the rapid increase in the cost of health care within Pima County. In 1978, the Foundation became independent of the Medical Society, which no longer has the right of approval over the selection of Directors for the Foundation.

4. Of approximately 1300 doctors in Pima County, some 400 doctors are members of the Foundation. Several Foundation-sponsored plans provide prepaid health insurance coverage to 6,000 men, women and children in Pima County, or little more than 1% of the total population (500,000) of the County. All of the member doctors and all of the policyholders are residents of Pima County. The 6,000

policyholders, if evenly dispersed among all 1,300 doctors, would amount to 4 or 5 patients per doctor. Spread among the 400 Foundation doctors, these 6,000 policyholders amount to roughly 15 patients per doctor.

5. The Medical Society has nothing whatever to do with Foundation-sponsored claim processing or with the setting of any premium rates or claim payment rates. Nor does the Medical Society have any authority over its 1,300 doctors with respect to what prices they charge in their individual practices, nor has it attempted to wield such authority.

6. Neither the Foundation nor the Medical Society have any formal connection with counterpart organizations in Maricopa County. The prepaid health plans sponsored by the Foundation is independent of any other organization. Any contact with other organizations has been casual and in a discussion of common concerns, but no conspiracy to fix prices has or will be entered into.

7. Most or all of the 400 members of the Foundation are also members of the Medical Society. However, neither the Foundation nor the Medical Society attempt to control the individual decisions of each doctor as to affiliation in either organization or as to policies adopted by either organization. An individual doctor may become affiliated with the Foundation, may decline to affiliate, or may change a previous decision. Membership in each organization is a matter of personal choice, and neither organization applies any direct or indirect pressure on the individual doctor.

8. Approximately 900 doctors in Pima County have not joined the Foundation. Since February, 1978, I have personally been told by a number of these non-participating doctors that they will not join because they feel the rates established by the Foundation are *too low, unreasonable and unfair.*

9. In view of its stated goal to help control the rising cost of health care, the Foundation and its sponsored plans have implemented the following control procedures:

(a) Since a large part of health cost dollars are consumed by long and sometimes unnecessary hospital confinements, the Foundation has adopted a formal program to review *every* instance of a policyholder being sent to the hospital. The Foundation employs a trained nurse who visits every policyholder while in the hospital, and certifies that there was medical justification for the admission and for the projected length of stay. To the best of my knowledge and belief, no other health plan in Pima County provides such comprehensive scrutiny of this major factor in cost of medical care.

(b) The Foundation acts as the claims agent for the private insurance carriers who actually underwrite the risks. Each claim is carefully reviewed to assure that the reimbursement for doctor's fees, medicine and hospital services do not exceed the *maximum* rates established by the Foundation.

10. The Foundation does not discriminate among doctors, pharmacists, hospitals or other suppliers of health care services and products. A policy holder may select a Foundation doctor or a non-Foundation doctor. The only possible difference is that the non-Foundation doctor has not contractually agreed to charge no more than the ceiling rate for his services. Thus, if a policyholder receives medical care from a non-Foundation doctor, he will be personally liable for any excess in charge by that doctor over the Foundation's maximum rate.

11. The Foundation does not discriminate between in-state doctors or out-of-state doctors. If a policyholder happens to be outside Arizona when the need for health care arises, the Foundation will process the claim for covered health items the same as for any other non-Foundation doctor who is located within Arizona. However, the fact remains that the 6,000 policyholders receive covered medi-

cal services from out-of-state doctors only a negligible number of times each year. The policyholder remains liable to that doctor for any charge that is in excess of the Foundation maximums.

12. The Foundation does not discriminate in any way against any hospital, pharmacist or other supplier of coveredf health services. The choice is wholly left up to the patient-policyholder. The Foundation's goal is simply to see that certain portions of covered expenses are insured, no matter which provider of health care (doctor, hospital, pharmacist) the policyholder selects.

13. According to my best information and belief, the presence of the Foundation's prepaid health plans covering approximately one percent of the population of Pima County tends to *increase competition* among health care providers and insurers. The controls which the Foundation exercises over the necessity of *each* hospital stay, together with rigid review of billings against Foundation *maximum rates*, tends to reduce the cost of health care for the 6,000 policyholders.

14. Three private carriers underwrite the various Foundation-sponsored plans, i.e., Arizona Blue Cross-Blue Shield, Pacific Mutual Life Insurance Company, and Connecticut General Life Insurance Company. Each of the Foundation's plans are rated retrospectively. In other words, the savings achieved by the Foundation's hospital review procedure, preliminary scrutiny and review for compliance with rate maximums—these savings are passed along to the policyholder in the subsequent year, once the carrier's overhead expenses are deducted.

15. The Foundation is a nonprofit corporation. It does not collect premiums or actually underwrite the risks, but it does act as the claims agent for the three private insurance carriers who underwrite the risks. These carriers, which are regulated by the State of Arizona, reimburse the Foundation for its cost-control services and claims payment. The reimbursement is calculated at 6% of monthly premiums

received by the carrier. The Foundation has no control over premiums charged by the carriers, other than the effective cost-savings measures that are reflected in lower premiums as the carriers retrospectively rate each plan's experience with loss.

16. The Foundation does exercise direct control over the establishment of maximum payment rates for medical services. However, these rates are a *ceiling*, not a *floor*, for Foundation members. Each doctor who is a member of the Foundation expressly agrees that covered expenses will be reimbursed at no more than the maximum rate established by the Foundation.

17. The Foundation rates are based upon the nature of the medical service rendered and the particular specialization of the doctor performing the service. The rates are set, in part, based upon a Relative Value Schedule and a Unit Conversion Factor.

18. The Foundation's Board of Directors weighs the various factors from industry sources and from their own experience in recommending a rate schedule. After its initial determination, the Board recommends the overall rate schedule to the Foundation's membership. The recommendation becomes effective after a majority of the 400 members approve it. Such payment schedules are reviewed every year or so.

19. The Foundation originally designed its health insurance plan, then contacted an insurance broker to find carriers who would provide the desired coverage. A unique feature in the contracts with the carriers is that the Foundation will perform cost-control review of hospitalization and review all charges against the ceiling rates.

20. Neither the Foundation or the Medical Society purchase any drugs or any medical products, but a minimal amount of office supplies are purchased each year. Doctors, in their individual capacities, do purchase drugs or medical products, or prescribe the same for their patients. The

Foundation has no control or concern over which particular drugs or products are thus favored by individual doctors, nor does the Foundation exercise or attempt to exercise such control with respect to individual pharmacists or hospitals. Thus, the price of drugs and medical supplies in Pima County and elsewhere is totally unrelated to the operation of the Foundation.

21. Based upon my personal knowledge, the Pima Foundation for Medical Care is concerned with the rising cost of medical care in Pima County. Inasmuch as these costs cannot be controlled in various circumstances without some kind of uniform cost ceilings, the Foundation has sponsored several prepaid health insurance plans to implement such maximum rates, and to eliminate unnecessary hospital stays by tight scrutiny from within the medical profession itself.

(Signature and notarization
omitted in printing.)

Filed - DEC 11, 1978
W. J. Furstenau, Clerk
U. S. District Court
For The District of Arizona

(Caption omitted in printing.)

RESPONSE OF DEFENDANT MARICOPA COUNTY MEDICAL SOCIETY TO PLAINTIFF'S MOTION FOR PARTIAL SUMMARY JUDGMENT ON THE ISSUE OF LIABILITY

Defendant Maricopa County Medical Society hereby opposes the plaintiff's Motion for Partial Summary Judgment on the Issue of Liability filed herein upon the grounds and for the reasons set forth in the Memorandum in Response to that Motion filed by Defendant Maricopa Foundation for Medical Care.

Respectfully submitted this 11th day of December, 1978.

(Signature omitted in printing.)

Filed - DEC 11, 1978
W. J. Furstenau, Clerk
U. S. District Court
For The District of Arizona

(Caption omitted in printing.)

DEFENDANT MARICOPA COUNTY MEDICAL SOCIETY'S RESPONSE TO PLAINTIFF'S STATEMENT OF UNDISPUTED MATERIAL FACTS ON ITS MOTION FOR PARTIAL SUMMARY JUDGMENT ON THE ISSUE OF LIABILITY

Most of the factual allegations contained in Plaintiff's Statement of Facts are directed to either the Maricopa or Pima Foundations for Medical Care. Defendant Maricopa County Medical Society is without sufficient knowledge to form a belief as to the truthfulness of the allegations contained in those statements of facts, and is therefore unable to controvert them.

1. Defendant Maricopa County Medical Society denies that it published a Foundation fee schedule (see General Objection No. 1 and Answer to Nos. 59 and 60 of Defendant Maricopa County Medical Society's Responses to Plaintiff's First Request for Admissions and Interrogatories).

2. Defendant Maricopa County Medical Society is unable to discern the meaning or relevance of Plaintiff's Statement No. 38, and therefore denies the same.

(Signature omitted in printing.)

Filed - DEC 12, 1978
W. J. Furstenau, Clerk
U. S. District Court
For The District of Arizona

(Caption omitted in printing.)

DEFENDANT MARICOPA FOUNDATION FOR MEDICAL CARE'S STATEMENT OF MATERIAL FACTS AS TO WHICH THERE IS A GENUINE ISSUE PRECLUDING PARTIAL SUMMARY JUDGMENT IN FAVOR OF THE PALINTIFF ON THE ISSUE OF SUBJECT MATTER JURISDICTION

Defendant Maricopa Foundation for Medical Care ("Maricopa Foundation") submits, pursuant to Local Rule 11(h), this statement of material facts which preclude partial summary judgment in favor of the plaintiff on the issue of subject matter jurisdiction.

A. Maricopa Foundation disputes plaintiff's contention that the following paragraphs of "Statement of Undisputed Facts Supporting Plaintiff's Motion for Partial Summary Judgment on the Issue of Subject Matter Jurisdiction" are not disputed:

1. With respect to Plaintiff's Statement 1, doctors in Maricopa County have not agreed to be bound by a fee schedule adopted by members of Maricopa Foundation. The only determinations with respect to fees charged for medical services which are made by Maricopa Foundation are with respect to maximum fees paid with respect to patients covered by Maricopa Foundation endorsed plans to member doctors of Maricopa Foundation. They have agreed to accept Maricopa Foundation's determination of maximum fees as payment in full for services performed by them on patients covered by Foundation endorsed plans when they billed the patient more than that amount. If the patient is billed less than that amount, the physician is paid the amount billed if the services are determined by Maricopa Foundation to have been medically appropriate. Maricopa Foundation does not and never has taken any

position with respect to the amount of fees a physician should bill any patient. (*See, e.g.*, Mitten Aff., November 17, 1978, paras. 3, 4.)

2. Maricopa Foundation has no information sufficient to admit or deny Plaintiff's Statement 2.

3. With respect to Plaintiff's Statement 3, Maricopa Foundation has entered into agreements with insurers Pacific Mutual Life Insurance Company, Washington National Life Insurance Company, Connecticut General Life Insurance Company, Metropolitan Life Insurance Company, Northwestern National Life Insurance Company, Cal Western Insurance Company, and Occidental Life Insurance Company, all of which transact business in Arizona wherein insurers agreed to reimburse doctors for services rendered to patients insured under Maricopa Foundation-endorsed health insurance plans in accordance with the their usual and customary fees charged for such services but not to exceed the maximum reimbursable level of compensation set forth in the Maricopa Foundation's minimum standards for Foundation-endorsed group insurance programs, except at the insurer's discretion. Maricopa Foundation has no information sufficient to admit or deny Plaintiff's statement with respect to Pima Foundation or other defendants. (*See, e.g.*, Response 12 of Defendant Maricopa Foundation for Medical Care's Responses to Plaintiff's First Request for Admissions and Interrogatories.)

4. Maricopa Foundation for Medical Care has no information sufficient to admit or deny Plaintiff's Statement 4.

5. Maricopa Foundation for Medical Care has no information sufficient to admit or deny Plaintiff's Statement 5.

6. Maricopa Foundation has no information sufficient to admit or deny Plaintiff's Statement 6.

7. Maricopa Foundation denies that the payment of premiums, claims and service fees on Maricopa Foundation endorsed insurance plans has involved a continuous stream of fee schedules, claims and continuous transfers of sub-

stantial sums of money across state lines and states it has no information sufficient to admit or deny the remainder of Plaintiff's Statement 7.

8. Maricopa Foundation denies that underwriting and operation of Maricopa Foundation endorsed insurance plans have involved a continuous stream of fee schedules, agreements, policies, claims and other materials and services across state lines and states it has no information sufficient to admit or deny the remainder of Plaintiff's Statement 8.

9. With respect to Plaintiff's Statement 9, if a patient insured under a Maricopa Foundation endorsed plan seeks treatment from a doctor outside the state of Arizona, the Foundation will pay the claim in the same manner as any claim for services performed by a doctor. Claims paid on Maricopa Foundation endorsed health insurance plans to out-of-state doctors are very few in number. Maricopa Foundation has no information sufficient to admit or deny Plaintiff's statement with respect to Pima Foundation. (*See*, Mitten Aff., December 11, 1978, para. 7.)

10. With respect to Plaintiff's Statement 10, the relative value schedules prepared and used by Maricopa Foundation are based in part upon the 1964 edition of the Relative Value Schedule adopted by the California Medical Association, in part upon the Relative Value Schedules adopted by the American Society of Anesthesiologist, and in part upon the Relative Value Schedules adopted by the American College of Radiology. Maricopa Foundation has no information sufficient to admit or deny Plaintiff's statement with respect to Pima Foundation, Pima Society, or Maricopa Society. (See, Responses 19, 21, and 23 of Defendant Maricopa Foundation for Medical Care's Responses to Plaintiff's First Request for Admissions and Interrogatories.)

11. With respect to Plaintiff's Statement 11, Maricopa Foundation has requested various professional organizations whose members are doctors to advise Maricopa Foundation only in connection with Maricopa Foundation's

determination of maximum reimbursable levels of compensation to doctors providing medical services to patients insured under Maricopa Foundation endorsed health insurance plans to be proposed to Maricopa Foundation's participating and cooperating members for adoption. Maricopa Foundation has no information sufficient to admit or deny Plaintiff's statement with respect to Pima Foundation, Pima Society, or Maricopa Society. (See, Responses 44 through 53 of Defendant Maricopa Foundation for Medical Care's Responses to Plaintiff's First Request for Admissions and Interrogatories.)

12. With respect to Plaintiff's Statement 12, Maricopa Foundation denies it obtained fee schedules and materials related to fee schedules through interstate association with other foundations for medical care. Maricopa Foundation has no information sufficient to admit or deny Plaintiff's statement with respect to Pima Foundaon, Pima Society, or Maricopa Society. (See, Mitten Aff., December 11, 1978, para. 4.)

13 With respect to Plaintiff's Statement 13, officers and employees of Maricopa Foundation have traveled to other states for meetings with representatives of other foundations for medical care for two purposes:

1. To study the claims processing operations used by other medical foundation; and,

2. To promote the foundation concept of health insurance.

No officer or employee of Maricopa Foundation has met with the representative of another medical foundation to discuss or to take any action with respect to fees charged for medical services by doctors in Arizona. (See, Mitten Aff., December 11, 1978, para. 4.)

14. With respect to Plaintiff's Statement 14, Maricopa Foundation has received only one grant from the federal government. The amount of the grant was less than $100,000.00 and its purpose was to study the desirability

and feasibility of Maricopa Foundation forming a Health Maintenance Organization. That study was not related to the functions performed by Maricopa Foundation as a medical foundation and no changes in the operations of Maricopa Foundation took place as a result of that study. Maricopa Foundation has no information sufficient to admit or deny Plaintiff's statement with respect to Pima Foundation. (See, Mitten Aff., December 11, 1978, para. 5.)

17. Maricopa Foundation has no information sufficient to admit or deny Plaintiff's Statement 17 with respect to the amounts of prescription drugs, equipment, goods and products which are manufactured and distributed in other states and shipped into Arizona.

18. Maricopa Foundation has no information sufficient to admit or deny Plaintiff's Statement 18 with respect to the amount of money paid annually for services, goods and products sold by doctors within the state of Arizona.

19. Maricopa Foundation has no information sufficient to admit or deny Plaintiff's Statement 19 with respect to the portion of the prices charged by the doctors in the State of Arizona which are paid through private health insurance.

20. Maricopa Foundation has no information sufficient to admit or deny Plaintiff's Statement 20 with respect to the amount paid by the state of Arizona for health insurance premiums in 1977.

21. Maricopa Foundation has no information sufficient to admit or deny Plaintiff's Statement 21 with respect to the number of persons in Arizona who had insurance protection against medical expenses or surgical expenses in 1975.

22. Maricopa Foundation has no information sufficient to admit or deny Plaintiff's Statement 22 with respect to the amount of premiums paid for private health insurance in Arizona.

23. Maricopa Foundation has no information sufficient to admit or deny Plaintiff's Statement 23.

24. Maricopa Foundation has no information sufficient to admit or deny Plaintiff's Statement 24.

25. Maricopa Foundation has no information sufficient to admit or deny Plaintiff's Statement 25.

B. Maricopa Foundation incorporates herein by reference the facts set forth in the affidavits of Anthony D. Mitten, sworn to November 17, 1978 and December 11, 1978, which set forth material facts precluding summary judgment in favor of plaintiff. December 11, 1978

(Signatures omitted in printing.)

(Caption omitted in printing.)

AFFIDAVIT OF
ANTHONY D. MITTEN

STATE OF ARIZONA }
} ss.
County of Maricopa }

ANTHONY D. MITTEN, being duly sworn, under oath deposes and says:

1. I am the Executive Director of defendant Maricopa Foundation for Medical Care ("Maricopa Foundation") and have been its chief administrative employee since its inception. I make this affidavit in opposition to plaintiff's motions for partial summary judgment on the issues of subject matter jurisdiction and liability and to supplement my affidavit sworn to November 17, 1978 which is incorporated herein by reference. I have personal knowledge with respect to the matters related in this affidavit.

2. The sole purpose for which relative value schedules and conversion factors have been prepared or used by the Maricopa Foundation is in determining the maximum reimbursable levels of compensation for medical services provided to those patients insured under Maricopa Foundation endorsed medical health insurance plans. The Maricopa Foundation does not publish or distribute relative value schedules or conversion factors used by the Foundation to non-members except to insurers who may be interested in underwriting Maricopa Foundations endorsed health insurance plans and persons eligible for membership in Maricopa Foundation who have expressed an interest in joining the Maricopa Foundation.

3. Conversion factors used by Maricopa Foundation to determine the maximum reimbursable levels of compensation for medical services provided to patients insured under Maricopa Foundation endorsed medical health insurance plans are revised when it is felt by Maricopa Foundation's Board of Trustees that they have fallen so far below usual

and customary fees in Maricopa County that doctors will resign from or refuse to renew membership in Maricopa Foundation if the conversion factors are not revised. Revision of those conversion factors is not conducted at any regular interval. The Maricopa Foundation has surveyed its members with respect to the fees they usually and customarily charge for their services on only two occasions. On both occasions the survey was conducted to aid Maricopa Foundation's Board of Trustees in determining whether to revise the maximum reimbursable levels of compensation for medical services provided to patients insured under Maricopa Foundation endorsed medical health insurance plans and the nature of the revisions which the Board of Trustees would submit to the participating and cooperating members of Maricopa Foundation for their approval. On three other occasions such revisions have been submitted to participating and cooperating members for their approval without any such survey.

4. Officers and employees of Maricopa Foundation have traveled to other states for meetings with representatives of other foundations for medical care for two purposes: (1) to study the claims processing operations used by other medical foundations; and (2) to promote the Foundation concept of health insurance. At no time, to my knowledge, has any officer or employee of Maricopa Foundation met in another state with a representative of another medical foundation or an association of doctors to discuss or take any action with respect to fees charged for medical services by doctors in Arizona.

5. The Maricopa Foundation has received only one grant from the Federal Government. The amount of the grant was less than $100,000 and its purpose was to study the desirability and feasibility of Maricopa Foundation forming a

Health Maintenance Organization. That study was not related to the functions performed by Maricopa Foundation as a medical foundation and no changes in the operations of Maricopa Foundation took place as a result of that study.

6. To the best of my knowledge, information and belief, at no time has the Board of Trustees of Maricopa Foundation recommended to the membership or the membership of Maricopa Foundation approved a maximum reimbursable level of compensation for medical services provided to patients insured under Maricopa Foundation endorsed medical health insurance plans in excess of what Maricopa Foundation's Board of Trustees believed to be the prevailing average or median usual and customary fee charged by doctors in Maricopa County for their services.

7. Virtually all of the member doctors of the Maricopa Foundation and almost all of the policyholders insured under Maricopa Foundation endorsed health insurance plans are residents of Maricopa County, Arizona. The vast majority of claims paid on Maricopa Foundation endorsed health insurance plans are paid to Arizona doctors for services rendered in Arizona. Claims paid on Maricopa Foundation endorsed health insurance plans to out-of-state doctors are very few in number.

8. The Maricopa Foundation does not purchase any drugs, medical equipment, goods or products. Maricopa Foundation does not have or exercise any control over the particular drugs, medical equipment, goods or products purchased by doctors, pharmacists or hospitals or the prices charged by them for drugs or medical products, equipment or goods. To the best of my knowledge, information and belief, the prices paid for drugs and medical products in Maricopa County and elsewhere are not affected in any way by the operation of Maricopa Foundation.

9. To the best of my knowledge, information and belief, at no time has Maricopa Foundation taken any action to request, urge or even suggest that a doctor increase the fee charged to any patient or taken any action with respect to

any doctor as a result of any fee charged by a doctor to any patient, other than to bring to the attention of the Arizona Board of Medical Examiners, those instances in which, in the opinion of the Board of Trustees of Maricopa Foundation, the fee charged by a doctor is so excessive as to constitute unprofessional conduct pursuant to A.R.S. § 32-1451.

(Signature and notary clause omitted in printing.)

(Caption omitted in printing.)

AFFIDAVIT OF
GARY L. SWINGLE

STATE OF ARIZONA }
} ss.
County of Maricopa }

GARY L. SWINGLE, being duly sworn, under oath deposes and says:

1. I am an associate of the law firm of Brown & Bain, P.A., attorneys for defendant Maricopa Foundation for Medical Care ("Maricopa Foundation"). I make this affidavit in support of Maricopa Foundation's Motion for Order Compelling Discovery.

2. In support of its motion for a preliminary injunction, plaintiff compared graphically "the relationship between foundation fee schedules and the payments made by the Industrial Commission of Arizona since 1970 for medical and anesthesiological services." Memorandum in Support of Application for Order to Show Cause and Motion for Preliminary Injunction dated October 25, 1978 at pp. 6-7. In opposing Maricopa Foundation's Motion for Order Compelling Discovery, plaintiff states "... that memorandum refers only to payments made by the Industrial Commission," not to relative value schedules, unit conversion factors, or fee schedules used or referred to by the Industrial Commission and therefore, the discovery sought by Maricopa Foundation is "completely irrelevant to any issue in this lawsuit." Plaintiff's Response to Defendant Maricopa Foundation for Medical Care's Motion for Order Compelling Discovery dated December 8, 1978 at p. 5.

3. The Industrial Commission of Arizona is charged by law with the responsibility to fix a schedule of fees to be charged by physicians attending injured employees, which shall be reviewed annually by the Commission. A.R.S. § 23-908. Pursuant to this charge, the Industrial Commission of Arizona publishes a "MEDICAL FEE SCHEDULE." An-

nexed hereto as Exhibit A is a true copy of the first 38 pages and Appendix I of "Medical Fee Schedule Adopted by the Industrial Commission of Arizona" dated December 1, 1970 ("Arizona Industrial Commission Fee Schedule"). On information and belief the Arizona Industrial Commission Fee Schedule is currently used by the Industrial Commission of Arizona to determine payments made by it and fees charged by physicians attending injured employees.

4. On information and belief, the Arizona Industrial Commission has annually established, pursuant to A.R.S. § 23-908, separate unit values and conversion factors for each of the five sections of the Arizona Industrial Commission Fee Schedule. The Arizona Industrial Commission Fee Schedule contains a relative value schedule divided into four sections: "Medicine," "Surgery," "Radiololgy," and "Laboratory" based on the 1964 California Relative Value Studies, published by the California Medical Association. The Arizona Industrial Commission Fee Schedule states that the Arizona Industrial Comission has approved the American Society of Anesthesiologists' Relative Value Guide (Second edition, 1967) for use with its conversion factor to establish fees for anesthesiology.

5. The opening page of the Arizona Industrial Commission Fee Schedule contains the following statement:

> "This Medical Fee Schedule, with the pertinent conversion factors adopted by The Industrial Commission of Arizona (see "resolution"), establishes the maximum fees that can be charged by physicians and surgeons to insurance carriers or self-insured employers for services performed for employees under workmen's compensation coverage."

6. The Arizona Industrial Commission Fee Schedule specifies that fees are to be calculated in the following manner:

"The amount of fee is to be calculated by multiplying the unit value (listed under the specific code number for a specific procedure) by the conversion factor established for each section in the schedule (see "Resolution"). Formula: Unit Value × Conversion Factor = Fee."

7. At the beginning of each section of the Arizona Industrial Commission Fee Schedule, the following statements appear:

"In billing, the physician must include the Code Number as assigned to the [medical, surgical, radiological, or laboratory] procedure involved and use the Unit Value prescribed by the Industrial Commission to determine his fee. Billing Formula: Unit Value × Conversion Factor = Fee."

8. A comparison of the "payments made by the Industrial Commission" with the maximum insurance reimbursement levels to physicians for services to patients insured under Maricopa Foundation endorsed health insurance reveals that in some instances the Arizona Industrial Commission Fee Schedule provides higher payments to physicians, and in some instances it provides the same payments as the maximum reimbursement rate of Maricopa Foundation endorsed health insurance plans.

9. It is respectfully submitted that the foregoing facts amply demonstrate the relevance to this action of the materials sought by Maricopa Foundation's Motion for Order Compelling Discovery.

(Signature and notary clause omitted in printing.)

95

MEDICAL FEE SCHEDULE

Adopted By

THE INDUSTRIAL COMMISSION OF ARIZONA

PHOENIX, ARIZONA DECEMBER 1, 1970

EXHIBIT A

STATE OF ARIZONA

MEDICAL FEE SCHEDULE for PHYSICIANS

adopted by

THE INDUSTRIAL COMMISSION OF ARIZONA

Bruce C. Thoeny, Chairman

Frank G. Murphy, Vice Chairman

John L. Ahearn, Member

Robert W. Knox, Member

Hugh W. Stewart, Member

December 1, 1970

Robert L. Kley, Director

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(by Alphabet with Code Numbers designated)

Because the Industrial Commission has adopted the 1964 California Relative Value Studies as the basis for this schedule of fees, the following statement is in order:

"Portions of the Relative Value Studies are taken from the copyrighted material of the California Medical Association and are reproduced with the permission of the California Medical Association. Grateful acknowledgement is made to them for the use of this information."

It must be stressed, however, that this schedule of fees as such and the conversion factors to be applied thereto are the determination of The Industrial Commission of Arizona.

FOREWORD

In 1925, when the Arizona Legislature passed the State's first Workmen's Compensation Act, The Industrial Commission of Arizona was established to administer that compensation law.

In 1943, industrial insurance coverage was extended by the State under the Arizona Occupational Disease Disability Law to cover certain job-connected diseases.

Thus for 43 years, the Industrial Commission was responsible, both for the administration of these workmen's compensation laws, and for the processing of all claims entered under those laws.

Then in 1968, when the Legislature reorganized the Industrial Commission, the ICA retained its regulatory role, to administer and enforce the laws for insurance coverage of industrial injuries and occupational diseases. Processing of claims for industrial injuries occurring since Jan. 1, 1969, was assigned to the State Compensation Fund and other authorized private insurance carriers. However, the Industrial Commission still retained the responsibility for processing all claims filed before Jan. 1, 1969, as well as no-insurance claims and claims filed under occupational disease disability laws.

As stated in the following Resolution, the Industrial Commission is charged with fixing a schedule of fees to be charged by physicians attending injured employees. The statutes also give the ICA full authority to make rules and regulations reasonably required in the performance of its duties.

Physicians attending employees under industrial insurance coverage are obligated by law to charge according to the schedule of fees herein adopted. Accurate calculation of fees based upon this schedule, the prompt filing of reports

and bills for payment, and the use of forms prescribed are essential to early and correct remuneration for a physician's services and can be vital in the award of benefits to the workman and his dependents.

RESOLUTION

WHEREAS pursuant to the provisions of A.R.S. § 23-908 (1968), The Industrial Commission of Arizona is charged with the responsibility of, and has full power, jurisdiction and authority to fix a schedule of fees to be charged by physicians attending injured employees, which shall be reviewed annually by the Commission, and

WHEREAS, the Commission, after carefully reviewing all material received and developed in order to evaluate the fee schedule for physicians, in its regular meeting on September 15, 1970, unanimously voted to approve the following:

1. Adoption of the 1964 California Relative Value Studies as the basis for the schedule which the Commission will publish to have available on the effective date of December 1, 1970.

2. Continuation of approval of the use of the A.S.A. Relative Value Study as the basis of charges for anesthesia.

3. Conversion factors to be applied to the new schedule effective December 1, 1970:

	CONVERSION FACTOR
(a) Medicine	$ 7.0
(b) Surgery	6.5
(c) Radiology	6.5
(d) Laboratory	6.0
(e) Anesthesia	7.0

NOW, THEREFORE, BE IT RESOLVED that The Industrial Commission of Arizona adopts the schedule of fees presented to it for its consideration at its regularly schedule meeting on October 27, 1970, and that the fees to be charged by physicians attending injured employees shall be in accordance with said schedule of fees, and

BE IT FURTHER RESOLVED that The Industrial Commission of Arizona adopts the following conversion factors to be applied to the schedule of fees herein adopted effective December 1, 1970 and to continue in effect until further action by this Commission:

	CONVERSION FACTOR
(a) Medicine	$ 7.0
(b) Surgery	6.5
(c) Radiology	6.5
(d) Laboratory	6.0
(e) Anesthesia	7.0

DATED at Phoenix, Arizona this 27th day of October, 1970.

APPROVED:

THE INDUSTRIAL COMMISSION OF ARIZONA

By /s/ Bruce C. Theony
Chairman

By /s/ Frank G. Murphy
Member

By /s/ John L. Ahearn
Member

By /s/ Robert W. Knox
Member

By /s/ Hugh W. Stewart
Member

ATTEST: Louise Suter
Secretary

LAWS AND RULES OF PROCEDURE

The following excerpts from the Arizona Revised Statutes and the Rules of Procedure Before The Industrial Commission of Arizona have direct application to physicians attending employees in Arizona who have been injured or incur an occupational disease as the result of and in the course of their employment.

A. GENERAL LAW: A.R.S., TITLE 23 — LABOR

CHAPTER 1. INDUSTRIAL COMMISSION
CHAPTER 6. WORKMEN'S COMPENSATION
CHAPTER 7. OCCUPATIONAL DISEASE DISABILITY

23-921. Administration of chapter

A. The industrial commission of Arizona is charged with the duties of the administration of chapters 6 and 7 of this title, and with the adjudication of claims for compensation arising out of provisions of this chapter and any of its members or assistants so authorized may:

1. Hold hearings at any place within the state or without the state by agreement of the parties.

2. Administer oaths.

3. Issue and serve by the commission's representatives, or by any sheriff, subpoenas for the attendance of witnesses and claimants and the production of reports, papers, contracts, books, accounts, documents and testimony. The commission may require the attendance and testimony of employers, their officers and representatives before any proceeding of the commission, and the production by employees of books, records, papers and documents.

4. Generally provide for the taking of testimony and for the recording of proceedings held in accordance with this chapter.

B. The commission may make and declare all rules and regulations which are reasonable required in the performance of its duties, including but not limited to rules of practice and procedure in connection with hearing and review proceedings. Such rules and regulations may provide for informal prehearing conferences in order to expedite claim adjudication, amicably dispose of controversies, narrow issues and simplify the method of proof at hearings.

C. The commission may incur such expenses as it determines are reasonably necessary to perform its authorized functions, which expenses shall be a charge against the administrative fund.

D. The commission may charge any person with contempt who refuses to comply with any order of the commission, upon application to the superior court. Any person held in contempt may be punished by a fine of not to exceed one thousand dollars.

23-929. Enforcement of chapter

Upon request of the commission the attorney general or under his direction the county attorney of the proper county, shall institute and prosecute the necessary actions or proceedings for the enforcement of the provisions of chapters 6 and 7 of this title, or for any penalty provided for therein, and shall prosecute or defend all actions or proceedings brought by or against the commission, or the members thereof in their official capacity. The commission may compromise any action.

23-932. Violations; penalty

A person who violates any provision of this chapter, commits any act therein prohibited, fails or refuses to perform any duty thereby imposed within the time prescribed by law or by the commission, or fails, neglects or refuses to obey an order of the commission or a judgment of a court made and entered under the provisions of this chapter, for which no penalty or punishment is otherwise specifically

provided, is guilty of a misdemeanor punishable by a fine of not less than fifty nor more than one thousand dollars for the first offense, and not less than one hundred nor more than five thousand dollars for each subsequent offense.

23-1061. Notice of accident; form of notice; application for compensation; reopening; payment of compensation

H. An employee may reopen his claim to secure an increase or rearrangement of compensation or additional benefits by filing with the commission a petition requesting the reopening of his claim upon the basis of new, additional or previously undisovered temporary or permanent condition, which petition shall be accompanied by a statement from a physician setting forth the physical condition of the employee relating to the claim. The payment for such reasonable and necessary medical examination and laboratory work expense shall be paid for by the employer's insurance carrier or the self-insuring employer if it accepts the petition as hereinafter provided. No other additional compensation shall be payable for any period prior to the date of filing of the petition.

23-1125. Violations and penalty

An employer who fails to comply with section 23-1161, or a person who violates any other provision of this chapter, does an act prohibited thereby, or fails or refuses to perform a duty imposed by this chapter within the time prescribed by law or by the commission for which no penalty is specifically provided, or fails, neglects or refuses to obey an order of the commission or a judgment of a court under the provisions of this chapter, is guilty of a misdemeanor punishable by a fine of not less than fifty nor more than one thousand dollars for the first offense, and not less than one hundred nor more than five thousand dollars for each subsequent offense.

23-1270. Processing of prior claims

The commission appointed pursuant to the provisions of chapter 1 of this title shall process all claims for injuries or disabling conditions under chapters 6 and 7 which occur prior to January 1, 1969 to the entry of a final award in accordance with the procedure and benefit levels in effect prior to the effective date of this section. Petitions to reopen filed subsequent to the effective date of this section shall be processed in accordance with the procedural provisions of chapters 6 and 7.

B. INDUSTRIAL INJURIES

23-908. Injury reports by employer and physician; fees of physician; violations; penalty

A. Every employer affected by the provision of this chapter, and every physician who attends an injured employee of such employer, shall file with the commission and the employer's insurance carrier from time to time a full and complete report of every known injury to the employee arising out of or in the course of his employment and resulting in loss of life or injury. Such report shall be furnished to the commission and such insurance carrier at times and in the form and detail the commission prescribes, and shall make special answers to all questions required by the commission under its rules and regulations.

B. The commission shall fix a schedule of fees to be charged by physicians attending injured employees, which shall be reviewed annually by the commission.

C. Information obtained by the attending physician or surgeon while in attendance on the injured person shall not be considered a privileged communication, if such information is requested by interested parties for a proper understanding of the case and a determination of the rights involved.

D. When an accident occurs to an employee, the employee shall forthwith report the accident and the injury resulting therefrom to the employer, and any physician employed by the injured employee shall forthwith report the accident and the injury resulting therefrom to the employer, the insurance carrier and to the commission.

E. When an accident occurs to an employee, the employer may designate in writing a physician chosen by the employer, who shall be permitted by the employee, or any person in charge of the employee, to make one examination of the injured employee in order to ascertain the character and extent of the injury occasioned by the accident. The physician so chosen shall forthwith report to the employer, the insurance carrier and the commission the character and extent of the injury as ascertained by him. If the accident is not reported by the employee or his physician forthwith, as required, or if the injured employee or those in charge of him refuse to permit the employer's physician to make the examination, and the injured employee is a party to the refusal, no compensation shall be paid for the injury claimed to have resulted from the accident. The commission may relieve the injured person or his dependents from the loss or forfeiture of compensation if it believes after investigation that the circumstances attending the failure on the part of the employee or his physician to report the accident and injury are such as to have excused them.

F. Within ten days after receiving notice of an accident, the employer shall inform his insurance carrier. The insurance carrier or self-insurer shall inform the commission on such forms and in such manner as may be prescribed by the commission.

G. Immediately upon notice to the employer of an accident resulting in an injury to an employee, the employer shall provide the employee with the name and address of the employer's insurance carrier, the policy number and expiration date.

H. Any person failing or refusing to comply with the provisions of this section is guilty of a misdemeanor punishable by a fine of not less than fifty nor more than two hundred dollars.

23-1021. Right of employee to compensation

A. Every employee coming within the provisions of this chapter who is injured, and the dependents of every such employee who is killed by accident arising out of and in the course of his employment, wherever the injury occurred, unless the injury was purposely self-inflicted, shall be entitled to receive and shall be paid such compensation for loss sustained on account of the injury or death, such medical, nurse and hospital services and medicines, and such amount of funeral expenses in event of death, as are provided by this chapter.

B. Every employee covered by insurance in the state compensation fund who is injured by accident arising out of and in the course of employment, and the dependents of every such employee who is killed, provided the injury was not purposely self-inflicted, shall be paid such compensation from the state compensation fund for loss sustained on account of the injury, shall receive such medical, nurse and hospital services and medicines, and such amount of funeral expenses in event of death, as provided in this chapter.

23-1026. Periodical medical examination of employee; effect of refusal or obstruction of examination or treatment

A. An employee who may be entitled to compensation under chapters 6 and 7 shall submit himself for medical examination from time to time at a place reasonably con-

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D. RULES OF PROCEDURE BEFORE THE INDUSTRIAL COMMISSION OF ARIZONA

RULE 1. Notice of Rules; Part of Record; Effective Date

(a) These rules apply to all actions and proceedings of or before the Commission pertaining to claims resulting from injuries which occured on or after January 1, 1969, and to Petitions to Reopen or Petitions for Readjustment or Rearrangement of Compensation filed on or after that date, and shall be deemed a part of the record in each such action or proceeding without formal introduction of, or reference to, the same. All parties are deemed to have knowledge of these rules. A copy of the rules will be supplied upon request to any person free of charge by the Commission. These rules shall become effective on September 1, 1970, and shall apply to all hearings held after October 1, 1970.

(b) These rules supersede all present Rules of Procedure Before The Industrial Commission of Arizona, and all present Rules of Procedure Before The Industrial Commission of Arizona are hereby repealed except for those which affect existing or accrued rights connected with the processing to entry of a final award of claims for injuries or disabling conditions which occurred prior to January 1, 1969, as provided by Arizona Revised Statutes, Section 23-1270.

RULE 2. Location of Office and Office Hours

The main office of The Industrial Commission of Arizona is located in Phoenix, Arizona. An office is also located in Tucson, Arizona. The offices are open for the transaction of business from eight (8) o'clock A.M. until five (5) o'clock P.M. every day except Saturdays, Sundays and legal holidays.

* * * *

RULE 17. Medical, Hospital and Burial Expense

(a) Medical, surgical and hospital benefits shall be in accordance with the various medical and surgical fee schedules adopted by the Commission and in effect at the time the services billed are rendered. Physician, nursing, hospital, drug or other medical bills shall be itemized and presented for payment to the employer, or if he is insured for medical, surgical or hospital benefits, to his insurance carrier. In the event the employee or employer has paid such items, reimbursement shall be made to the person paying same to the extent allowed by the fee schedules provided that receipted vouchers or bills are presented in support of a claim for reimbursement.

RULE 31. Maintenance of Claims File; contents; Inspection and Copying; Exchange of Medical Reports

(a) There shall be maintained at the claims office referred to in Rule 30, a claims file which shall be the repository of all employer's reports, medical and hospital reports, awards, orders, notices of claims status, wage data and all other items required by law to be maintained by the carrier affecting the claim.

(b) The claims file referred to shall be available for inspection and copying, subject to the provisions of subsection (c) hereof, by all interested parties or their authorized representatives to the Industrial Commission proceedings, including representatives of the Industrial Commission. Copies shall be furnished upon request at a charge not to exceed fifteen cents (15¢) per page.

(c) Documents or matters representing the work product of the insurance carrier, or its attorney, investigation and rehabilitation reports shall not be considered subject to inspection and copying as provided in subsection (b) hereof, and need not be maintained in the claims file.

* * * *

IV. CHECK-OFF LIST FOR PROCEDURES IN COMPENSATION CASES

(A copy of this check-off list may prove helpful to the physician as a guide sheet for the file of each workman's compensation case.)

( ) 1. If the employee claimant, at time of first treatment, does not bring an insurance carrier identification form from his employer requesting medical treatment, the physician should promptly check with the employer to determine if the employee was injured on the job, the name of the insurance carrier and the policy number.

( ) 2. At the time of first treatment, the physician should complete, in accurate detail, the "Physician's Initial Report" on Form ICA 102, and assist the employee in completing the upper portion ("Workman's Report") of the same form.

( ) 3. Within *eight* days after first treating the employee, the physician must send copies of the above Form ICA 102 to The Industrial Commission of Arizona, to the employer, and to the insurance carrier.

( ) 4. If the employee remains under medical care for more than seven days, the physician is to submit monthly progress reports (Form ICA 04-0427, or the equivalent) to the insurance carrier of self-insured employer, until his final report that the employee has returned to his job.

( ) 5. In cases where employee's condition warrants his submitting a "Workman's Supplemental Claim for Compensation" (Form ICA 04-0521, or the equivalent), the physician is to complete and sign his portion of that form.

INSTRUCTIONS FOR PHYSICIANS

( ) 6. If the physician releases the employee to "light work," he should make his report to the insurance carrier or self-insured employer, completing and signing the "Workman's Supplemental Claim Form" (Form ICA 04-0521 A, or the equivalent).

( ) 7. The physician's bills calculated according to the fixed medical fee schedules and the conversion factors fixed by the Industrial Commission, shall be submitted, once a month, to the insurance carrier, or the self-insured employer.

( ) 8. If the employee files a petition to reopen his claim on the basis of a new, additional or previously undiscovered disability or condition, the attending physician must submit an accompanying medical report if the petition is to be accepted for consideration (see Rule 33).

( ) 9. In respect to all occupational disease disability cases, the attending physician is to submit all reports and medical bills to the Industrial Commission.

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MEDICAL FEE SCHEDULE

(Arranged by Code Numbers)

I. Medicine
II. Surgery
III. Radiology
IV. Laboratory

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1. This Medical Fee Schedule, with the pertinent conversion factors adopted by The Industrial Commission of Arizona (see "Resolution"), establishes the maximum fees that can be charged by physicians and surgeons to insurance carriers or self-insured employers for services performed for employees under workmen's compensation coverage.

2. Unit values and conversion factors have been established separately for each of the sections included in this fee schedule: "Medicine," "Surgery," "Radiology," and "Laboratory." Fees to be charged for anesthesia are not listed in this schedule. See Appendix on Anesthesia.

3. The amount of fee is to be calculated by multiplying the unit value (listed under the specific code number for a specific procedure) by the conversion factor established for each section in this schedule (see "Resolution"). Formula: Unit Value × Conversion Factor = Fee.

4. Bills, submitted monthly by the attending physician, must be itemized by the description of procedure, code number, date of service and amount of charge. Any bill which does not contain the code number for the designated procedures will not be paid and will be returned for the necessary information. Each itemized procedure should be coded on a separate line.

5. Routine progress and routine final reports filed by the attending physician do not ordinarily command a fee.

6. Payment will be made for only one professional visit in any one day except when the submitted report clearly demonstrates the need for the additional visit and fee.

7. Fees for hospital, office or home visits, subsequent to the initial visit, are not to be added to coded surgical procedures performed in the same day.

MEDICINE

GENERAL INFORMATION AND INSTRUCTIONS

1. The following visits, examinations, consultations and similar services are the most frequently recurring and widely variable items of medical care. The time requirements of these services range from the briefest possible contact with the patient to the time-consuming interview and exhaustive examination needed to appraise a complex medical problem. The following gradation of services is listed in an attempt to reflect the relative values of the various times and skills required.

2. (†): Those items preceded by a (†) may be used by all physicians, but are to be used when the problem appears to be of a serious or difficult nature requiring additional time and/or special study, e.g., Internal Medicine, Pediatrics, Neurology, etc. Written reports shall be furnished upon request.

3. "Sv." Items: "Sv," in the value column indicates the value is to be calculated as the sum of the various services rendered, (e.g., office, home, nursing home or hospital visit, consultation or detention, etc.) according to the rules covering those services.

4. Medical care of an unusual or unlisted value which represents a type of service over and beyond listed procedures may occur. If substantiated "By Report" (see Rule 5), additional unit values may be warranted.

5. "By Report": When the value of a procedure is to be determined "By Report," information concerning the nature, extent and need for the procedure or service, the time, the skill and the equipment necessary, etc., is to be furnished. A detailed clinical record is not necessary.

6. "Independent Procedure": Certain of the listed procedures are commonly carried out as an integral part of a total service and as such do not warrant a separate charge. When such a procedure is carried out as a separate entity, not immediately related to other services, the indicated value for "Independent Procedure" is applicable.

7. Values for other diagnostic, therapeutic, surgical, x-ray and laboratory procedures are listed in the sections entitled "Surgery," "Radiology" and "Laboratory."

8. Necessary drugs, supplies and materials provided by the physician may be charged for separately.

9. Routine office treatment principally by injections of drugs other than antibiotics requires authorization by the carrier or self-insured employer for each series of 10 after the first series of 10.

10. Consultation must be authorized, except in emergencies, and consultant must render his own report.

11. Attending physician may submit a claim for consultant's fee only when such service is requested by carrier or self-insured employer.

12. Missed individual appointments for consultants, without prior notification, will be compensated at 50 per cent of consultation fee.

In billing, the physician must include the Code Number as assigned to the medical procedure involved, and use the Unit Value prescribed by the Industrial Commission to determine his fee.

Billing Formula: Unit Value × Conversion Factor = Fee

OFFICE VISITS

CODE NUMBER		UNIT VALUE
9000	Initial office visit, routine, new patient or new illness, history and examination	2.0
†9001	Initial (or subsequent) office visit, complete diagnostic history and physical examination, established patient or minor chronic illness, including initiation of diagnostic and treatment programs	3.5
†9002	Initial (or subsequent) office visit, complete diagnostic history and physical examination, new patient or major illness, including initiation of diagnostic and treatment programs	6.0
9003	Follow-up office visit, brief; e.g., routine injection, minimal dressing, etc.	0.8
9004	Follow-up office visit, routine	1.0
†9005	Follow-up office visit necessitating professional care, over and above routine visit	1.5
†9006	Follow-up office visit, prolonged, over and above 9005	2.0
†9007	Follow-up office visit necessitating complete re-examination and re-evaluation of patient as a whole (continuing illness)	3.0
†9008	Re-examination, comprehensive diagnostic history and re-evaluation, established patient, (annual type)	4.0
0001	Special narrative report evaluating status as to temporary or permanent disability, when requested by employer or carrier	3.0

HOME or NURSING (CONVALESCENT) HOME VISITS

9010	Initial home visit, routine, new patient or new illness, history and examination	2.5
†9011	Initial home visit, complete diagnostic history and physical examination, established patient or minor chronic illness, including initiation of diagnostic and treatment programs	4.0
†9012	Initial home visit, complete diagnostic history and physical examination, new patient or major illness, including initiation of diagnostic and treatment programs	7.0
9013	Follow-up home visit, brief; e.g., routine injection, minimal dressing, etc.	1.5
9014	Follow-up home visit, routine	2.0
†9015	Follow-up home visit necessitating professional care, over and above routine visit	3.0

MEDICINE

CODE NUMBER		UNIT VALUE
†9017	Follow-up home visit necessitating complete re-examination and re-evaluation of patient as a whole (continuing illness)	3.5

HOSPITAL VISITS

9020	Initial hospital visit, routine history and physical examination, including initiation of diagnostic and treatment programs and preparation of hospital records	3.0
†9021	Initial hospital visit, complete diagnostic history and physical examination, established patient or minor chronic illness, including initiation of diagnostic and treatment programs and preparation of hospital records	5.0
†9022	Initial hospital visit, complete diagnostic history and physical examination, new patient or major illness, including initiation of diagnostic and treatment programs and preparation of hospital records	6.0
9024	Follow-up hospital visit, routine	1.0
†9025	Follow-up hospital visit necessitating care over and above routine visit	2.0
†9027	Follow-up hospital visit necessitating complete re-examination and re-evaluation of patient as a whole	3.0

CONSULTATIONS

A consultation is considered to denote services rendered by a physician whose opinion or advice is requested in the evaluation and/or treatment of a patient's condition. When the consultant-physician thereupon assumes the continuing care of the patient, any subsequent service rendered by him will no longer be considered as a consultation. If the medical problem necessitates the concurrent services and skills of two or more physicians, each physician will be entitled to the listed values of his service. Second examinations by the consultant in regard to the same or related problem should be billed as visits, and not as consultations unless otherwise authorized.

†9028	Consultation requiring limited examination and/or evaluation of a given system but not requiring a complete diagnostic history and examination, home, office or hospital	3.0
†9029	Consultation requiring more extensive examination and/or evaluation but not requiring complete diagnostic history and examination, home, office or hospital	5.0
†9030	Consultation requiring complete diagnostic history and examination and/or evaluation, office, home or hospital	7.0

MEDICINE

CODE NUMBER		UNIT VALUE
0002	Consultation of unusual complexity (in excess of scope of service identified by 9028, 9029 or 9030) necessitating diagnostic history and examination, extensive review of prior medical records, compilation and assessment of data and the preparation of a special report, home, office or hospital ..... (A higher fee may be allowed if more than three hours are required to complete the consultation.)	10.0 to 15.0
0003	Attendance at operation or autopsy and report of findings when requested by employer or carrier	10.0 to 15.0
0004	Expert opinion and written report without examination, based on a hypothetical case or clinical records, x-rays, laboratory findings, autopsy or other data	7.0 to 14.0
0006	Expert testimony at hearing, per one-half day session: first hour or part thereof ..... each additional hour or part thereof	$50.00 $25.00

IMMUNIZATIONS (UNCOMPLICATED)

9040	Immunization(s), per visit (smallpox vaccination includes reading) ..... (For desensitization to horse serum, etc., see 9415)	1.0

PSYCHIATRIC SERVICES

9050	Psychotherapy, office, hospital or home, verbal, drug augmented or other methods, one hour	5.0
9053	group (maximum 8 persons per group) one and one half hours, per person	1.5
9055	Electroshock (per treatment), sub-convulsive	4.0
9056	convulsive	5.0
9057	Insulin shock (per treatment), sub-coma	4.0
9058	coma	6.0
9059	Metrazol convulsive shock (per treatment)	5.0
9060	Psychometric testing (one hour) with written report	5.0
9064	Inpatient care, prolonged (chronic case)	Sv.

OTHER SERVICES

9070	Mileage, per mile, one way, beyond 10 mile radius of point of origin (office or home) ..... (Within large metropolitan areas, a travel-time basis may be appropriate, by report.)	0.2

CODE NUMBER		UNIT VALUE
†9071	Dentention—Prolonged detention with patient in critical condition requiring constant attention beyond usual service, per hour	5.0
9073	Night Calls: When calls are made between 8:00 p.m. and 8:00 a.m. in response to requests received during those hours, add to listed value for visit	1.0
9074	Services rendered during unusual hours for the patient's convenience may warrant an additional charge.	
9075	Special Reports: (i.e., insurance forms, narrative reports, review of medical records). When information more than that necessary to establish or to clarify a patient's status in requested (e.g., more than the standard reporting form) or a request is made for review of medical records and report, a charge adequate to cover the value of the additional service is justified.	

SPECIFIC DIAGNOSTIC SERVICES

Listed values may be added to other significant services rendered at the same visit.

Values for items 9101 to 9277 include laboratory procedure(s), interpretation and physicians' services (except surgical services as listed in the section on Surgery), unless otherwise stated.

For other similar services, see appropriate sections.

9101	Electrocardiogram with interpretation and report	3.0
9102	tracing only, without interpretation and report	1.5
9103	interpretation and report only	1.5
9104	with exercise test	5.0
9105	tracing only without interpretation and report	2.5
9106	interpretation and report only	2.5
9107	single lead (for rhythm) with interpretation	1.0
9112	Phonocardiogram with interpretation and report	4.0
9113	with indirect carotid artery tracing or similar study	5.0
9115	Vectorcardiogram (VCG), with or without EKG, interpretation and report	5.0
9116	when part of other diagnostic studies	4.0
9120	Venous pressure determination	1.0
9122	Circulation time, per test (not to exceed 2.0 units) (For radioisotope tests, see 7836.)	1.0
9123	Recording of direct arterial pressure tracings (independent procedure) (Recording of intracardiac pressures with evaluation and interpretation included as part of items 2330-2335)	4.0

CODE NUMBER		UNIT VALUE
9126	Cardiac output (Fick) (independent procedure) (excluding cardiac catheterization—see 2330-2335) ..... (For radio-isotope methods, see 7835)	5.0
9127	Dye dilution studies, indicator dye curves	1.0
9128	cardiac output, initial (independent procedure)	5.0
9129	subsequent, same study period, each (independent procedure) ..... (When dye dilution studies are part of right heart catheterization, maximum units allowed will be 18; when part of combined right and left heart catheterization, maximum units allowed will be 22.)	2.5
9150	Arterial puncture to obtain blood specimen	1.5
9151	pH, arterial blood, including puncture	3.0
9152	Blood volume (dye method) including total plasma and blood cell volumes	6.0
9153	pH, venous blood	1.5
9154	Carbon dioxide content (Van Slyke), initial	2.0
9155	subsequent, same study	1.0
9156	Oxygen saturation (Van Slyke), initial	3.0
9157	subsequent, same study ..... (Total same study, not to exceed 11 units.)	1.0
9160	Oxygen saturation (Cuvette), initial	2.0
9161	subsequent, same study ..... (Total same study, not to exceed 5.5 units.)	0.5
9164	Oxygen saturation (ear oximeter) all readings same study	1.5
9168	Oxygen content (Van Slyke), initial	2.0
9169	subsequent, same study ..... (Sum of items 9153, 9154, 9156, 9157, 9160, 9161, 9168 and 9169 when part of one study, not to exceed 20 units)	1.5
9175	Oxygen content and saturation, carbon dioxide content and pH	5.0
9176	pH, pCO^2 and related values (Astrup type), initial (for arterial puncture, see 9150)	3.0
9177	subsequent, each	2.0
9190	Peripheral vascular disease studies	by report
9192	Plethysmography	by report
9193	Temperature gradient studies	by report
9194	Thermogram	by report

APPENDIX I: ANESTHESIA

GENERAL INFORMATION

The code and unit values for anesthesia services are not included in this medical fee schedule. The Industrial Commission has established the conversion factor to be used in determining fees for anesthesia services and has approved the American Society of Anesthesiologists Relative Value Guide (2nd Edition, 1967) as basis for such charges.

1. The total values for anesthesia services include pre- and post-operative visits, the administration of the anesthetic and the administration of fluids and/or blood incident to the anesthesia or surgery.

2. Calculated values for anesthetic services are to be used only when the anesthesia is personally administered by a licensed physician and surgeon who remains in constant attendance during the procedure for the sole purpose of rendering such anesthetic service.

3. If the general or regional anesthetic is administered by the attending surgeon, the value shall be fifty per cent (50%) of the calculated value.

4. In procedures where no value is listed, the basic portion of the calculated value will be the same as listed for a comparable procedure.

5. Necessary drugs and materials provided by the physician anesthetist may be charged for separately.

6. Where unusual detention with the patient is essential for the safety and welfare of such patient, the necessary time will be valued on the same basis as indicated below for anesthesia time.

7. No fee will be allowed for local infiltration or digital block anesthesia administered by the operating surgeon.

8. Anesthesia time starts with the beginning of the administration of the anesthetic agents and ends when the anesthetist is no longer in personal attendance (when the patient may be safely placed under customary post-operative supervision).

Filed - DEC 12, 1978
W. J. Furstenau, Clerk
U. S. District Court
For The District of Arizona

(Caption omitted in printing.)

DEFENDANT MARICOPA FOUNDATION FOR MEDICAL CARE'S STATEMENT OF MATERIAL FACTS AS TO WHICH THERE IS A GENUINE ISSUE PRECLUDING SUMMARY JUDGMENT IN FAVOR OF THE PLAINTIFF ON THE ISSUE OF LIABILITY

Defendant Maricopa Foundation for Medical Care ("Maricopa Foundation") submits, pursuant to Local Rule 11 (h), this statement of material facts which preclude partial summary judgment in favor of the plaintiff on the issue of liability.

A. Maricopa Foundation disputes plaintiff's contention that the following paragraphs of "Statement of Undisputed Facts Supporting Plaintiff's Motion for Summary Judgment on the Issue of Liability" are not disputed:

1. With respect to Plaintiff's Statement 1, the membership of Maricopa Foundation includes medical doctors, osteopaths, podiatrists, and oral surgeons. Maricopa Foundation has no information sufficient to admit or deny plaintiff's statement with respect to Pima Foundation, Pima Society, and Maricopa Society (*See, e.g.*, Exhibit MF-122 to Plaintiff's First Request for Admissions.)

2. With respect to Plaintiff's Statement 2, the only determinations with respect to fees charged for medical services which are made by Maricopa Foundation are with respect to maximum fees paid with respect to patients covered by Maricopa Foundation endorsed plans to the member doctors of Maricopa Foundation. They have agreed to accept Maricopa Foundation's determination of maximum fees as payment in full for services performed by them on patients covered by Foundation endorsed plans when they bill the patient more than that amount. If the patient is billed less than that amount, the physician is paid the amount billed if

the services are determined by Maricopa Foundation to have been medically appropriate. Maricopa Foundation does not and never has taken any position with respect to the amount of fees a physician should bill any patient. (*See, e.g.*, Mitten Aff., Nov. 17, 1978, paras. 3 and 4.)

3. Maricopa Foundation has no information sufficient to admit or deny Plaintiff's Statement 3.

4. With respect to Plaintiff's Statement 4, to determine the maximum reimbursable payment to a doctor for services provided to a patient insured under a Maricopa Foundation endorsed health insurance plan, one must refer both to a relative value schedule and a conversion factor, and peer review determines that the services are medically necessary or appropriate. Maricopa Foundation has no information sufficient to admit or deny plaintiff's statement with respect to Pima Foundation. (*See, e.g.*, Response 17 of Defendant Maricopa Foundation for Medical Care's Responses to Plaintiff's First Request for Admissions and Interrogatories.)

6. With respect to Plaintiff's Statement 6, Maricopa Foundation only uses unit conversion factors to determine the maximum reimbursable level of compensation payable by the insurer to doctors for services provided to patients insured under a Maricopa Foundation endorsed health insurance plan. (Mitten Aff., Nov. 17, 1978, para. 4.)

7. With respect to Plaintiff's Statement 7, the relative value schedules used by Maricopa Foundation are based in part upon the 1964 Edition of the Relative Value Schedule adopted by the California Medical Association, the Relative Value Schedules adopted by the American Society of Anesthesiologists, and the Relative Value Schedules adopted by the American College of Radiology. Maricopa Foundation has no information sufficient to admit or deny plaintiff's statement with respect to Pima Foundation, Pima Society,

or Maricopa Society. (*See, e.g.*, Responses 19, 21, and 23 of Defendant Maricopa Foundation for Medical Care's Responses to Plaintiff's First Request for Admissions and Interrogatories.)

8. With respect to Plaintiff's Statement 8, the Maricopa Foundation has only prepared relative value schedules for use in Arizona to determine the maximum reimbursable levels of compensation payable by the insurer to doctors for services provided to patients insured under Maricopa Foundation endorsed health insurance plans. (Response 29 of Defendant Maricopa Foundation for Medical Care's Responses to Plaintiff's First Request for Admissions and Interrogatories.)

9. With respect to Plaintiff's Statement 9, the Maricopa Foundation has revised its relative value schedules. It has in some instances increased and in some instances decreased the unit value used to determine the maximum reimbursable level of compensation payable by the insurer to doctors for services provided to a patient insured under a Maricopa Foundation endorsed health insurance plan. The sole purpose for which relative value schedules have been prepared or used by the Maricopa Foundation is in determining the maximum reimbursable levels of compensation for medical services provided to those patients insured under Maricopa Foundation endorsed medical health insurance plans. Maricopa Foundation has no information sufficient to admit or deny plaintiff's statement with respect to Pima Foundation, Pima Society, or Maricopa Society. Maricopa Foundation has not publicized and encouraged the use of relative value schedules. (*See, e.g.*, Responses 28 and 32 of Defendant Maricopa Foundation for Medical Care's Responses to Plaintiff's First Request for Admissions and Interrogatories; Mitten Aff., Dec. 11, 1978, para. 2.)

10. With Respect to Plaintiff's Statement 10, Maricopa Foundation's maximum reimbursement levels of compensation to doctors providing medical services to patients insured under Maricopa Foundation endorsed health insurance plans are determined using unit conversion factors for six categories of relative values. (*See, e.g.*, Exhibit MF-63 to Plaintiff's First Request for Admissions; Mitten Aff., Dec. 11, 1978, para. 2.)

11. With respect to Plaintiff's Statement 11, participating and cooperating members of Maricopa Foundation have the right to vote on the adoption of maximum reimbursable levels of compensation to doctors providing medical services to patients insured under Maricopa Foundation endorsed health insurance plans. These votes have been conducted by mail ballot. Maricopa Foundation has no information sufficient to admit or deny plaintiff's statement with respect to Pima Foundation. Maricopa Foundation has not polled its members as to relative value schedules and unit conversion factors they prefer or relative value schedules and unit conversion factors they consider appropriate for Maricopa Foundation. (*See, e.g.*, Response 34 of Defendant Maricopa Foundation for Medical Care's Responses to Plaintiff's First Request for Admissions and Interrogatories.)

12. With respect to Plaintiff's Statement 12, the Maricopa Foundation has on two occasions surveyed its members as to their usual and customary fees for medical services, and as to what conversion factors and relative value schedules they used for the purpose of calculating their usual and customary fees for medical services. (*See, e.g.*, Responses 37 through 43 of Defendant Maricopa Foundation for Medical Care's Responses to Plaintiff's First Request for Admissions and Interrogatories.)

13. With respect to Plaintiff's Statement 13, Maricopa Foundation has on a non-periodic basis requested various professional organizations whose members are doctors to advise Maricopa Foundation in connection with Maricopa

Foundation's determination of maximum reimbursable levels of compensation to doctors providing medical services to patients insured under Maricopa Foundation endorsed health insurance plans to be proposed to Maricopa Foundation's participating and cooperating members for adoption. Maricopa Foundation has not polled them as to relative value schedules and unit conversion factors their members use or prefer or the fees their members usually charge. (*See* Responses 44 through 53 of Defendant Maricopa Foundation for Medical Care's Responses to Plaintiff's First Request for Admissions and Interrogatories.)

14. With respect to Plaintiff's Statement 14, Maricopa Foundation repeats its response to statement 13.

15. With respect to Plaintiff's Statement 15, Maricopa Foundation has only used information obtained from surveys of doctors and from professional organizations to advise Maricopa Foundation's Board of Trustees in connection with its determination of maximum reimbursable levels of compensation to doctors providing medical services to patients insured under Maricopa Foundation endorsed health insurance plans to be proposed to Maricopa Foundation's participating and cooperating members for adoption. Maricopa Foundation repeats its response to plaintiff's statement 13. Maricopa Foundation has no information sufficient to admit or deny plaintiff's statement with respect to Pima Foundation. (*See* Responses 44 through 54 of Defendant Maricopa Foundation for Medical Care's Responses to Plaintiff's First Request for Admissions and Interrogatories.)

16. With respect to Plaintiff's Statement 16, at no time has Maricopa Foundation set a maximum reimbursable level of compensation for medical services provided to patients insured under Maricopa Foundation endorsed medical health insurance plans in excess of what Maricopa Foundation's Board of Trustees believed to be the prevailing average or median usual and customary fee charged by doctors in Maricopa County for their services. Maricopa

Foundation has no information sufficient to admit or deny plaintiff's statement with respect to Pima Foundation. (Mitten Aff., Dec. 11, 1978, para. 6.)

17. With respect to Plaintiff's Statement 17, Maricopa Foundation has in the past sent to its members, and to non-member doctors who request membership information and applications, lists of conversion factors used by it to determine maximum reimbursable levels of compensation to doctors providing medical services to patients insured under Maricopa Foundation endorsed health insurance plans. Maricopa Foundation does not publish or distribute relative value schedules or conversion factors used by it to non-members except to insurers who may be interested in underwriting Maricopa Foundation endorsed health insurance plans and persons eligible for membership in Maricopa Foundation who have expressed an interest in joining the Maricopa Foundation. Maricopa Foundation has no information sufficient to admit or deny plaintiff's statement with respect to Pima Foundation, Pima Society, and Maricopa Society. (*See* Responses 57 and 58 of Defendant Maricopa Foundation for Medical Care's Responses to Plaintiff's First Request for Admissions and Interrogatories; Mitten Aff., Dec. 11, 1978, para. 2.)

18. With respect to Plaintiff's Statement 18, Maricopa Foundation has only sent to Pima Foundation conversion factors used by Maricopa Foundation to determine maximum reimbursable levels of compensation to doctors providing medical services to patients insured under Maricopa Foundation endorsed health insurance plans for use for that purpose. Maricopa Foundation has no information sufficient to admit or deny that Pima Foundation subsequently adopted any Maricopa Foundation conversion factors or relative value schedules. (*See*, Response 63 of Defendant Maricopa Foundation for Medical Care's Responses to Plaintiff's First Request for Admissions and Interrogatories.)

20. With respect to Plaintiff's Statement 20, Maricopa Foundation has endorsed certain health insurance plans which are underwritten by private insurers and meet Maricopa Foundation "minimum standards for Foundation-endorsed group insurance plans." Maricopa Foundation has no information sufficient to admit or deny this statement with respect to Pima Foundation. (*See*, Response 11 of Defendant Maricopa Foundation for Medical Care's Responses to Plaintiff's First Request for Admissions and Interrogatories.)

21. With respect to Plaintiff's Statement 21, the minimum standards for Maricopa Foundation endorsed health isurance plans include a list of medical services, goods, and equipment for which the insurer is required to provide reimbursement to insured patients. Maricopa Foundation has no information sufficient to admit or deny this statement with respect to Pima Foundation. (*See, e.g.*, Responses 9 through 12 of Defendant Maricopa Foundation for Medical Care Responses to Plaintiff's First Request for Admissions and Interrogatories.)

22. With respect to Plaintiff's Statement 22, the Maricopa Foundation has entered into agreements with insurers wherein insurers agree to reimburse doctors for services rendered to patients insured under Maricopa Foundation endorsed health insurance plans in accordance with their usual and customary fees charged for such services but not to exceed the maximum reimbursement level of compensation set forth in the Maricopa Foundation's "minimum standards for Foundation-endorsed group insurance programs" except at the insurer's discretion. Maricopa Foundation does not affect in any way prices paid for goods and products sold by doctors to Foundation policyholders and has no price list or schedule for them. Maricopa Foundation has no information sufficient to admit or deny this

statement with respect to Pima Foundation. (*See*, Response 12 of Defendant Maricopa Foundation for Medical Care's Responses to Plaintiff's First Request for Admissions and Interrogatories; Mitten Aff., Dec. 11, 1978, para. 8.)

23. With respect to Plaintiff's Statement 23, maximum reimbursement levels of compensation to doctors providing medical services to patients insured under Maricopa Foundation endorsed health insurance plans have a direct and substantial effect upon insurance reimbursements paid to doctors and health insurance premiums charged for Foundation endorsed health insurance plans.

24. With respect to Plaintiff's Statement 24, it is the practice of Maricopa Foundation to advise insurers underwriting health insurance plans endorsed by Maricopa Foundation in advance of expected changes to maximum reimbursable levels of compensation to doctors providing medical services to patients insured under Maricopa Foundation endorsed health insurance plans. Defendant has no information sufficient to admit or deny this statement with respect to Pima Foundation, Pima Society, or Maricopa Society. (*See*, Response 61 of Maricopa Foundation for Medical Care's Responses to Plaintiff's First Request for Admissions and Interrogatories.

25. With respect to Plaintiff's Statement 25, participating and cooperating members of Maricopa Foundation have agreed to be bound during the period of membership with respect to services provided to patients insured under Maricopa Foundation endorsed plans to accept a determination by the Maricopa Foundation consistent with the schedule adopted by the membership for determining the maximum reimbursable payment as full payment of fees for medical services rendered by them to such patients unless the patient refuses to assign benefits to the member or has multiple health insurance coverage. Maricopa Foundation has no information sufficient to admit or deny this state-

ment with respect to Pima Foundation. (*See*, Response 14 of Maricopa Foundation for Medical Care's Responses to Plaintiff's First Request for Admissions and Interrogatories.)

26. With respect to Plaintiff's Statement 26, Maricopa Foundation repeats its response to statement 25 and further states that pursuant to the minimum standards for Foundation endorsed group insurance programs, assignment of benefits by insureds to doctors who are foundation members is automatic. (*See*, Response 16 of Maricopa Foundation for Medical Care's Responses to Plaintiff's First Request for Admissions and Interrogatories.)

27. With respect to Plaintiff's Statement 27, with respect to some health insurance plans endorsed by Maricopa Foundation, participating and cooperating members of Maricopa Foundation may submit assigned claims for doctors' services provided to patients insured under those plans to Maricopa Foundation. With respect to some health insurance plans endorsed by Maricopa Foundation, Maricopa Foundation writes drafts on the insurer's account as agent of the insurer to pay assigned claims for participating and cooperating members of Maricopa Foundation. Maricopa Foundations has no information sufficient to admit or deny plaintiff's statement with respect to Pima Foundation. (*See*, Responses 65 and 66 of Defendant Maricopa Foundation for Medical Care's Responses to Plaintiff's First Request for Admissions and Interrogatories.)

28. With respect to Plaintiff's Statement 28, members of Maricopa Foundation review claims submitted for services performed on patients insured under Foundation plans to determine if those services were medically necessary or appropriate and if they were adequately described in the claim. Maricopa Foundation does not review prices for goods and products. Maricopa Foundation only reviews doctors' prices for services to the extent of determining whether a fee charged by a doctor is so excessive as to constitute unprofessional conduct pursuant to A.R.S. § 32-1451

which should be brought to the attention of the Arizona Board of Medical Examiners. Maricopa Foundation has no information sufficient to admit or deny plaintiff's statement with respect to Pima Foundation. (*See*, Response 71 of Defendant Maricopa Foundation for Medical Care's Responses to Plaintiff's First Request for Admissions and Interrogatories; Mitten Aff., Dec. 11, 1978, paras. 8, 9.)

29. With respect to Plaintiff's Statement 29, the claim forms approved for use by participating and cooperating members of Maricopa Foundation have spaces for setting forth the usual and customary fee they have billed to the patient. Maricopa Foundation has a preferred claim form but other claim forms may be used. Maricopa Foundation has no information sufficient to admit or deny plaintiff's statement with respect to Pima Foundation, Pima Society, or Maricopa Society. (*See*, Responses 67 and 69 of Defendant Maricopa Foundation for Medical Care's Responses to Plaintiff's First Request for Admissions and Interrogatories.)

30. With respect to Plaintiff's Statement 30, Maricopa Foundation enters membership agreements with its participating and cooperating members annually. A copy of a current application is Exhibit A to the November 17, 1978 Mitten Affidavit. Maricopa Foundation has no information sufficient to admit or deny plaintiff's statement with respect to Pima Foundation. (*See, e.g.*, Response 13 of Defendant Maricopa Foundation for Medical Care's Responses to Plaintiff's First Request for Admissions and Interrogatories.)

31. With respect to Plaintiff's Statement 31, applications for participating and cooperating membership in Maricopa Foundation provide that those members agree to be bound during the period of membership applied for with respect to services provided to patients insured under Maricopa Foundation endorsed health insurance plans, to accept a determination by Maricopa Foundation consistent with the schedule adopted by the membership for determining the

maximum reimbursable payment as full payment of fees for medical services rendered by them to such patients unless the patient refuses to assign benefits to the member or has multiple health insurance coverage. Maricopa Foundation has no information sufficient to admit or deny plaintiff's statement with respect to Pima Foundation. (*See, e.g.*, Response 14 of Defendant Maricopa Foundation for Medical Care's Responses to Plaintiff's First Request for Admissions and Interrogatories.)

32. With respect to Plaintiff's Statement 32, Maricopa Foundation was founded, *inter alia*, to promote the practice of medicine in Maricopa County on a fee for service basis. Maricopa Foundation has no information sufficient to admit or deny plaintiff's statement with respect to Pima Foundation. (*See, e.g.*, Response 91 of Defendant Maricopa Foundation for Medical Care's Responses to Plaintiff's First Request for Admissions and Interrogatories.)

34. Maricopa Foundation has no information sufficient to admit or deny plaintiff's statement 34.

35. Maricopa Foundation has no information sufficient to admit or deny plaintiff's statement 35 with respect to Pima Foundation.

36. With respect to Plaintiff's Statement 36, the only class of member of the Maricopa Foundation with the privilege of voting in the Maricopa Foundation is administrative members, except that participating and cooperating members have the right to vote on the adoption of maximum reimbursable levels of compensation to doctors providing medical services to patients insured under Maricopa Foundation endorsed health insurance plans and that the Board of Trustees of Maricopa Foundation has full and sole power to control and manage the property and conduct the affairs and business of Maricopa Foundation and have general voting power with respect thereto. Maricopa Foundation has no information sufficient to admit or deny plaintiff's state-

ment with respect to Pima Foundation. (*See, e.g.*, Response 4 of Defendant Maricopa Foundation for Medical Care's Responses to Plaintiff's First Request for Admissions and Interrogatories.)

37. With respect to Plaintiff's Statement 37, Maricopa Foundation's participating and cooperating members have the right to vote on the adoption of maximum reimbursable levels of compensation of doctors providing medical services to patients insured under Maricopa Foundation endorsed health insurance plans, including adoption of conversion factors used with relative value schedules for that purpose. Maricopa Foundation has no information sufficient to admit or deny plaintiff's statement with respect to Pima Foundation. (*See*, Response 34 of Defendant Maricopa Foundation for Medical Care's Responses to Plaintiff's First Request for Admissions and Interrogatories.)

38. Maricopa Foundation has no information sufficient to admit or deny plaintiff's statement 38.

39. Maricopa Foundation has no information sufficient to admit or deny Plaintiff's Statement 39.

40. Maricopa Foundation has no information sufficient to admit or deny Plaintiff's Statement 40.

41. Maricopa Foundation denies Plaintiff's Statement 41 with respect to Maricopa Foundation. Maricopa Foundation has no information sufficient to admit or deny the statement with respect to Pima Foundation, Pima Society, or Maricopa Society. (*See, e.g.*, Responses 25 and 26 of Defendant Maricopa Foundation for Medical Care's Responses to Plaintiff's First Request for Admissions and Interrogatories.)

B. Maricopa Foundation incorporates herein by reference the facts set forth in the affidavits of Anthony D. Mitten, sworn to November 17, 1978 and December 11, 1978, which set forth material facts precluding summary judgment in favor of plaintiff. December 11, 1978.

(Signatures omitted in printing.)

(Caption omitted in printing.)

Filed - DEC 12, 1978
W. J. Furstenau, Clerk
U. S. District Court
For The District of Arizona

MARICOPA FOUNDATION FOR MEDICAL CARE'S MEMORANDUM IN OPPOSITION TO PLAINTIFF'S MOTION FOR PARTIAL SUMMARY JUDGMENT ON THE ISSUE OF LIABILITY

Preliminary Statement

Plaintiff's motion for patrial summary judgment on the issue of liability should be denied for three reasons:

1. There are genuine issues as to material facts precluding summary judgment;

2. The acts of Maricopa Foundation for Medical Care ("Maricopa Foundation") are not *per se* violations of the Sherman Act or Arizona's antitrust laws;

3. Plaintiff has not carried its burden of establishing that the acts of Maricopa Foundation violate the Sherman Act or Arizona's antitrust laws under the Rule of Reason.

Argument

A. There are Genuine Issues of Material Facts Which Preclude Granting Plaintiff's Motion for Partial Summary Judgment on the Issue of Liability.

It is characteristic of plaintiff's conduct of this litigation that its motion for partial summary judgment and "Statement of Undisputed Facts" were prepared and filed prior to the time that it received the responses of Maricopa Foundation to Plaintiff's First Request for Admissions and prior to the deposition of the representative of Maricopa Foundation which plaintiff had noticed. As Maricopa Foundation's Statement of Disputed Material Facts, filed pursuant to

Local Rule 11(h), demonstrates, plaintiff would not have taken up the Court's time with this motion if it had waited until it had received the discovery which it requested before filing the motion.

Plaintiff claims "Defendants do not and cannot dispute that they and their members have used and continue to use agreed upon fee schedules to set prices for services, goods and products sold by doctors in Arizona." (Plaintiff's Memorandum, p. 2.) Once again, plaintiff has misunderstood the facts. The affidavit of Anthony D. Mitten sworn to November 17, 1978, and delivered to plaintiff prior to its filing its motion for partial summary judgment on the issue of liability, clearly establishes that Maricopa Foundation does not itself or in combination with anyone else set prices for services, goods and products sold by doctors in Arizona. That affidavit states

> "4. The only determinations with respect to fees charged for medical services which are made by Maricopa Foundation are with respect to maximum fees paid with respect to patients covered by Foundation endorsed plans to participating members in Maricopa Foundation. They agree to accept the Foundation's determination of maximum fees as payment in full for services performed by them on patients covered by Foundation endorsed plans when they bill the patient more than that amount. If the patient is billed less than that amount, the physician is paid the amount billed if the services are determined by Maricopa Foundation to have been medically appropriate. Maricopa Foundation does not and never has taken any position with respect to the amount of fees a participating member or other physician should bill with respect to any medical care for any patient. . . ."

Furthermore, as plaintiff is well aware,

> "Each participating member in Maricopa Foundation executes an application for membership, a true copy of which is attached hereto as Exhibit "A". That application for membership specifically states 'I understand

and agree that participating membership in the Foundation shall not affect the method of computation or amount of fees billed by me with respect to any medical care for any patient.' " *Id.*, para. 3.

The affidavit of Anthony D. Mitten, sworn to December 11, 1978, also makes clear that Maricopa Foundation's Board of Trustees does not believe that the maximum reimbursable level of compensation for medical services provided to patients insured under Maricopa Foundation endorsed medical health insurance plans is in excess of the prevailing average or median usual and customary fee charged by doctors in Maricopa County for their services. (Aff., para. 6.) Furthermore, Maricopa Foundation exercises no control whatsoever over prices for goods and products sold by doctors in Arizona. (Aff., para. 8.) The only action Maricopa Foundation has ever taken with respect to fees charged by doctors is to bring to the attention of the Arizona Board of Medical Examiners pursuant to A.R.S. § 32-1451 those instances in which, in the opinion of the Board of Trustees of Maricopa Foundation, the fee charged by the doctor is so excessive as to constitute unprofessional conduct. (Mitten Aff., para. 9.) Plaintiff's extensive reliance upon a deposition of a representative of Pima Foundation as establishing what Pima Foundation does is irrelevant to any determination as to what Maricopa Foundation does.*

B. The Acts of Maricopa Foundation Are Not a Per Se Violation of the Sherman Act.

Plaintiff's contention that "The Supreme Court has made it unmistakably clear that members of the so-called 'learned professions' are subject to the same antitrust scrutiny as anyone else" (Plaintiff's Memorandum, p. 10) in

* Furthermore, review of the Gerdenics deposition and other evidence in the record will show that the out-of-context quotations from the deposition only relate to a hypothetical instance in which Pima Foundation's relative values and conversion factors were being used to determine a fee charged, not the actual practice in the community.

reliance upon *National Society of Professional Engineers v. United States*, _____ U.S. _____, 98 S. Ct. 1355 (1978) and *Goldfarb v. Virginia State Bar*, 421 U.S. 773 (1975) stands those opinions on their heads.

Neither case applied a *per se* rule to a factual situation which the Court determined to constitute price fixing. In the *Goldfarb* case, the Court went out of its way to state

> "The fact that a restraint operates upon a profession as distinguished from a business is, of course, relevant in determining whether that particular restraint violates the Sherman Act. It would be unrealistic to view the practice of professions and interchangeable with other business activities, and automatically to apply to the professions antitrust concepts which originated in other areas. The public service aspect, and other features of the professions, may require that a particular practice, which could properly be viewed as a violation of the Sherman Act in another context, be treated differently. We intimate no view on any other situation than the one with which we are confronted today."

421 U.S. at 788, n.17.

In *Professional Engineers*, the Court went out of its way to reiterate that "certain practices by members of a learned profession might survive scrutiny under the Rule of Reason even though they would be viewed as a violation of the Sherman Act in another context." 98 S. Ct. at 1362. The Court then quoted in its entirety note 17 from the *Goldfarb* decision in the text of the *Professional Engineers* decision.

In *Professional Engineers*, although, as plaintiff notes, the Supreme Court stated that the activities of defendants constituted an agreement interfering with free market prices which was illegal on its face, nonetheless, the court felt it necessary to undertake an elaborate analysis for the purpose of determining that defendants' conduct was not justified under the Rule of Reason. The court affirmed not because it found a *per se* violation but "Because we are satisfied that the asserted defense rests on a fundamental

misunderstanding of the Rule of Reason frequently applied in antitrust litigation. . . ." 98 S. Ct. at 1360. If plaintiff's contentions were correct, none of the analysis in *Professional Engineers* would have been necessary. The court merely would have stated that defendants' conduct constituted a *per se* violation and affirmed on that ground.

Plaintiff also has ignored the controlling decision of *Boddicker v. Arizona State Dental Association*, 549 F.2d 626 (9th Cir.), *cert. denied*, 434 U.S. 825 (1977).* In *Boddicker*, the Ninth Circuit made clear that pursuant to *Goldfarb*, a *per se* analysis should not be applied to professions.

> ". . . . the Supreme Court does not require that the practices challenged here be treated the same as would be proper if dentistry were merely a commercial enterprise.
>
> As we interpret the Court, to survive a Sherman Act challenge a particular practice, rule, or regulation of a profession, whether rooted in tradition or the pronouncements of its organizations, must serve the purpose for which the profession exists, *viz.* to serve the public. That is, it must contribute directly to improving service to the public. Those which only suppress competition between practitioners will fail to survive the challenge. This interpretation permits a harmonization of the ends that both the professions and the Sherman Act serve.
>
> We recognize this interpretation provides only the principle to be employed in deciding specific cases. It is not a blueprint which will resolve all controversies and by which the professions can check their struc-

* This is particularly strange, since plaintiff relied extensively on the *Boddicker* decision to support its motion for partial summary judgment on the issue of subject matter jurisdiction. (Plaintiff's Memorandum in Support of Motion for Partial Summary Judgment on the Issue of Subject Matter Jurisdiction, p. 8.)

> tures to determine whether they comply with the Sherman Act. Any such blueprint must await additional guidance by the Supreme Court and resolution of specific cases by this and other courts."

549 F.2d at 632.

Plaintiff's attempt to apply a mechanical, unthinking, and rigid *per se* analysis to defendants in this action, as if they were selling gasoline instead of engaged in the medical profession, is not well-founded.* Applying the Ninth Circuit's standard from the *Boddicker* case, Maricopa Foundation's activities clearly must be subject to a Rule of Reason analysis, weighing any alleged suppression of competition against the contribution to the public. Since Maricopa Foundation is undisputedly a vehicle by which the medical profession offers a low cost health care alternative to people of the community, the Rule of Reason must be applied.

C. The Acts of Maricopa Foundation Are Not a Per Se Violation of Arizona's Antitrust Laws.

Maricopa Foundation agrees with plaintiff that the standards enunciated by the Supreme Court in applying the Sherman Act should also be used in applying Arizona's antitrust laws. A.R.S. § 44-1412. Since the Supreme Court would apply the Rule of Reason as the standard for judging the activities of Maricopa Foundation under the Sherman Act, it should also be applied as the standard for judging the activities of Maricopa Foundation under Arizona's antitrust laws.

D. Plaintiff Has Not Carried Its Burden of Establishing That the Acts of Maricopa Foundaiton Violate the Rule of Reason.

Plaintiff relies exclusively on *Professional Engineers* to support its contention that the activities of Maricopa Foun-

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* The Fifth Circuit has also rejected mechanical application of *per se* rules developed for business activities. See *Hennessey v. National Collegiate Athletic Ass'n*, 564 F.2d 1136 (5th Cir. 1977).

dation violate the Rule of Reason. *Professional Engineers* was an action by the United States against the National Society of Professional Engineers in which it alleged the Society's canon of ethics which prohibited its members from submitting competitive bids for engineering services violated Section 1 of the Sherman Act.

The Supreme Court formulated the legal standard to be applied under the Rule of Reason as follows:

> [T]he inquiry mandated by the Rule of Reason is whether the challenged agreement is one that promotes competition or one that suppresses competition.

98 S. Ct. at 1365. Applying this standard to the facts before it, the Court found the canon amounted to an agreement among competitors to refuse to discuss prices with potential customers prior to the selection of an engineer—a clear suppression of competition.

Unlike the canon of ethics in *Professional Engineers*, the activities of Maricopa Foundation promote, rather than suppress, competition. First, plaintiff's contention that Maricopa Foundation fixes prices is not supported by the facts. There is no undisputed factual basis to find competition is suppressed. Second, Maricopa Foundation was established to provide residents of Maricopa County with a competitive alternative to closed panel prepaid health insurance plans (HMO's). (Mitten Aff., Nov. 17, 1978, para. 2) At present, Maricopa Foundation endorsed insurance plans compete in the open market with the other types of health insurance plans available in Arizona. The Foundation's maximum reimbursement levels, which are attacked by plaintiff, are essential to the concept and operation of the Foundation insurance plans. These maximum reimbursement levels have helped Maricopa Foundation control the rising cost of health care for policyholders of Foundation endorsed health insurance plans. The Foundation establishes maximum levels of reimbursement believed not to exceed usual and customary fees in Maricopa County. (Mitten Aff., Dec. 11, 1978, para. 6.) By providing the alter-

native of Foundation endorsed insurance plans to consumers, the Maricopa Foundation promotes competition. Therefore, its activities are squarely within the Rule of Reason as enunciated by the Supreme Court in *Professional Engineers* and the Ninth Circuit in *Boddicker*.

Conclusion

Plaintiff's motion for partial summary judgment on the issue of liability should be denied. There are genuine issues as to numerous material facts. In the event that this Court finds that there is no genuine issue as to controlling material facts, Maricopa Foundation's activities should be judged under the Rule of Reason and found not to constitute antitrust violations because they promote, rather than suppress, competition and serve the public.

December 11, 1978.

(Signature omitted in printing.)

Filed DEC 21, 1978
W. J. Furstenau, Clerk
U. S. District Court
For The District of Arizona

(Caption omitted in printing.)

STATEMENT OF UNDISPUTED FACTS SUPPORTING PLAINTIFF'S MOTION FOR PARTIAL SUMMARY JUDGMENT ON THE ISSUE OF LIABILITY WITH SUPPLEMENTAL REFERENCES

Pursuant to Rule 11(h), Rules of Practice of the United States District Court for the District of Arizona 1978, plaintiff filed and served on November 20, 1978 a Statement of Undisputed Facts Supporting Plaintiff's Motion for Partial Summary Judgment on the Issue of Liability. That Statement was based upon and contained references to the documents and testimony available to plaintiff as of November 20, 1978. Since that date plaintiff has taken the deposition of defendant Maricopa Foundation for Medical Care by its designee Anthony D. Mitten on November 22, 1978 (hereinafter Mitten Deposition), and has received defendants' responses to Plaintiff's First Request for Admissions (Exhibits A, B, and C), defendants' stipulations with respect to the authenticity of certain documents, (Exhibit D) and additional business records of defendants (*e.g.*, Exhibits E through M.) For the convenience of the Court and parties, plaintiff hereby submits the identical Statement of Undisputed Facts which it filed on November 20, 1978 with supplemental references to the testimony, admissions and documents which plaintiff has discovered since that date.

1. Each of the defendants is an association of doctors. (*See, e.g.*, Exhibit MF-122 to Plaintiff's First Request for Admissions; Deposition of Defendant Pima Foundation for Medical Care by its designee Mary Gerdenics, taken November 14, 1978 (hereinafter "Gerdenics Deposition"), Exhibit 45, Defendants' Answers to Interrogatory No. 1; Defendant Maricopa County Medical Society's Responses

to Plaintiff's First Request for Admissions and Interrogatories, attached hereto as Exhibit C (hereinafter "Maricopa Society's Admissions") No. 309; Plaintiff's First Request for Admissions and Interrogatories and Responses of Defendant Maricopa Foundation for Medical Care, attached hereto as Exhibit 3 (hereinafter "Maricopa Foundation's Admissions") Nos. 310, 311; Response of Defendant Pima Foundation for Medical Care to Plaintiff's First Request for Admissions and Interrogatories (attached hereto as Exhibit A) (hereinafter "Pima Foundations's Admissions") No. 428.)

2. Over 1000 doctors in Maricopa County have agreed to abide by the fee schedules adopted by the membership of defendant Maricopa Foundation for Medical Care (hereinafter "Maricopa Foundation"). (*See, e.g.*, Exhibits MF-51 and MF-112 through MF-118 to Plaintiff's First Request for Admissions; Mitten Deposition, Exhibit 55; Maricopa Foundation's Admissions No. 268; Exhibit MF-64 to Plaintiff's First Request for Admissions, § I, ¶10.)

3. Over 400 doctors in Pima County have agreed to abide by the fee schedules adopted by the membership of defendant Pima Foundation for Medical Care (hereinafter "Pima Foundation"). (*See, e.g.*, Gerdenics Deposition, pp. 27-28, Exhibits 6, 45, 46, 48 § I, ¶8; Exhibit PF-125 to Plaintiff's First Request for Admissions; Opposition to Plaintiff's Motion for Partial Summary Judgment on the Issue of Subject Matter Jurisdiction filed by Defendant Pima Foundation (hereinafter "Pima Foundation's Opposition"), p. 14; Affidavit of Thomas P. Finley attached to Pima Foundation's Opposition (hereinafter "Finley Affidavit") ¶7.)

4. To determine the price allowed for a doctor's service under the foundation fee schedules, one must refer to both a relative value schedule and a unit conversion factor. (*See, e.g.*, Gerdenics Deposition, pp. 24-26, Exhibit 48, § IV ¶3(A); Exhibits MF-70, MF-102, PF-109, and MF-64, § IV, ¶3(A), to Plaintiff's First Request for Admissions; Maricopa Foundation's Admissions No. 17; Mitten Deposition, Vol. I

pp. 90-92, 99-100; Pima Foundation's Admissions No. 17; Finley Affidavit ¶17; Pima Foundation's Opposition, at p. 8 ("In the present case, the uniform fee schedule is drawn in part from a physician's Relative Value Schedule.")

5. A relative value schedule is a compilation of medical services which assigns a comparative unit value to each service listed. (*See, e.g.*, Gerdenics Deposition, pp. 25, 41-49, Exhibit 18; Mitten Deposition, Vol. I pp. 70-96; Exhibits E, F, G, and H.)

6. A unit conversion factor is a dollar or number value used to multiply the unit value of a service into a dollar amount payable for that service. (*See, e.g.*, Gerdenics Deposition, pp. 28, 44; Exhibit MF-102 to Plaintiff's First Request for Admissions; Mitten Deposition, Vol. I pp. 96-100, Exhibit 28. *See* Maricopa Foundation's Admissions No. 160.)

7. Defendants and their members have used relative value schedules prepared by the California Medical Association, the American Society of Anesthesiologists and the American College of Radiology. (Defendants' Answers to Interrogatory No. 13, Gerdenics Deposition, pp. 41-49, 82-86, Exhibit 18; Mitten Deposition, Vol. I pp. 71-82, Vol. II pp. 97-100; Maricopa Foundation's Admissions Nos. 19, 21, 23, 160; Pima Foundation's Admissions Nos. 19, 21, 23, 38, 323; *see* Exhibits E, F, G, and H.)

8. The Maricopa Foundation prepared a relative value schedule for use by Arizona doctors. (Maricopa Foundation's Answer to Interrogatory No. 13; Exhibits MF-24, MF-49, MF-70, MF-71, MF-76 and MF-120 to Plaintiff's First Request for Admissions; Maricopa Foundation's Admissions Nos. 18, 29, 196. *See* Mitten Deposition, Vol. I pp. 71-76, 83-84, Exhibits 38, 66; Exhibits E and M.) (The Pima Foundation has also prepared relative value schedules. *See* Pima Foundation's Admissions No. 18.)

9. In concert with their members and various groups of doctors in Arizona, defendants have:

(a) publicized and encouraged the use of certain relative value schedules;

(b) updated and revised the relative value schedules used by their members;

(c) increased the relative values accorded to some doctors' services on the relative value schedules used by their members.

(*See, e.g.*, Gerdenics Deposition, pp. 84-86, Exhibit 48, § V; Exhibits PS-1, PF-1, PF-127 through PF-129, MF-47, MF-64, § V, MF-99, MF-100, MF-107 and MF-107A to Plaintiff's First Request for Admissions; Maricopa Society's Admissions No. 197; Maricopa Foundation's Admissions Nos. 28, 32, 122, 136, 137, 139, 193, 248, 261, 262, 263, 283, 296; Mitten Deposition, Vol. I pp. 73-84, 95-96, Vol. II pp. 97-100, Exhibits 56, 65, 66; Pima Foundation's Admissions Nos. 28, 32, 318, 319, 321, 322, 323, 326, 328, 329, 330, 331, 332, 333, 334, 335, 336, 399, 410, 414, 424.)

10. Foundation fee schedules provide unit conversion factors for six categories of relative values (*See* Exhibits PF-1, PF-146, MF-63 and MF-121 to Plaintiff's First Request for Admissions; Gerdenics Deposition, Exhibits 20, 25, 26, 27, 28, 29; Mitten Deposition, Vol. I pp. 96-104, Exhibit 28 (attached hereto as Exhibit I); Maricopa Foundation's Admissions Nos. 93, 94, 95, 96, 229, 233, 304; Pima Foundation's Admissions Nos. 344, 349, 364, 413, 426.)

11. Foundation fee schedules have been adopted periodically by majority vote of foundation members conducted by mail ballot. (*See, e.g.*, Gerdenics Deposition, pp. 63-74, Exhibits 24, 25; Exhibits PF-3, PF-107, PF-111, PF-114, PF-132, PF-135, PF-151, PF-154, MF-1, MF-70, MF-88, MF-93, MF-95 and MF-102 to Plaintiff's First Request for Admissions; Mitten Deposition, Vol. I pp. 114-118, Vol. II pp. 10-11, Exhibits 28, 31, 34 (attached hereto as Exhibits I,

J, and K); Finley Affidavit ¶18; Maricopa Foundation's Admissions Nos. 34, 36, 156, 157, 158, 164, 234, 235; Pima Foundation's Admissions Nos. 34, 347, 348, 362, 363, 402, 403, 409, 412, 423, 425.)

12. The Maricopa Foundation has periodically polled its members with respect to:

(a) the fees they usually charge for their services;

(b) the relative value schedules and unit conversion factors they use or prefer;

(c) the relative value schedules and unit conversion factors they consider appropriate for foundation fee schedules.

(*See, e.g.*, Exhibits MF-1, MF-2, MF-3, MF-59, MF-72 and MF-97 to Plaintiff's First Request for Admissions; Maricopa Foundation's Admissions Nos. 37, 41, 54, 119, 153, 154, 225, 226, 257, 297, 298, 299, 301; Mitten Deposition, Vol. II pp. 90-92, Exhibits 59, 63.)

13. The Maricopa Foundation has periodically polled various doctors' associations with respect to:

(a) the fees their members usually charge for their services;

(b) the relative value schedules and unit conversion factors their members use or prefer;

(c) the relative value schedules and unit conversion factors which their members consider appropriate for foundation fee schedules.

(*See, e.g.*, Exhibits MF-6 through MF-19 and MF-27 through MF-46 to Plaintiff's First Request for Admissions; Maricopa Foundation's Admissions Nos. 44, 54, 123, 124, 130, 160, 256, 261, 269, 279, 281, 282, 284, 285, 286, 287, 290, 291, 292, 293, 295, 300; Mitten Deposition, Vol. II pp. 87-88, Exhibits 59, 61.)

14. Defendant foundations have consulted with various doctors' associations with respect to:

(a) the relative value schedules and unit conversion factors which their members use or prefer;

(b) the relative value schedules and unit conversion factors which their members consider appropriate for foundation fee schedules;

(c) the relative values to be accorded certain procedures;

(d) the services, goods and products sold by doctors for which coverage should be required under foundation plans.

(*See, e.g.*, Exhibits PF-109, PF-113, PF-169 through PF-182, PF-184 through PF-194, MF-57, MF-58, MF-60, MF-65 through MF-67, MF-77, MF-79, MF-81, MF-99, MF-100, MF-103 and MF-104 to Plaintiff's First Request for Admissions; Maricopa Foundation's Admissions Nos. 44, 54, 104, 105, 106, 107, 112, 113, 114, 122, 126, 134, 135, 137, 166, 167, 179, 183, 193, 237, 238, 251, 252, 253, 258, 260, 261, 262, 263, 283, 284, 285, 287, 290, 291, 292, 293, 295, 296; Mitten Deposition, Vol. I p. 96, Exhibits 11, 59, Pima Foundation's Admissions Nos. 44, 54, 319, 320, 321, 322, 323, 326, 328, 329, 330, 331, 332, 333, 334, 335, 336, 360, 414.)

15. Defendant foundations have consulted with their members and various doctors' associations in connection with the preparation of foundation fee schedules. (*See, e.g.* Exhibits MF-3, MF-4, and MF-62 to Plaintiff's First Request for Admissions; Maricopa Foundation's Admissions Nos. 44, 54, 250; Mitten Deposition, Exhibits 59, 61, 66; Pima Foundation's Admissions Nos. 44, 54, 319-338.)

16. Foundation conversion factors have been set higher than average and median doctors' prices shown by price surveys. (*See, e.g.*, Exhibits MF-51, MF-71 to Plaintiff's First Request for Admissions; *see* Maricopa Foundation's Admissions Nos. 227 throught 234 and 269 through 276; Mitten Deposition, Vol. II pp. 92-94, Exhibit 63.)

17. Defendants have published and distributed foundation fee schedules to members and non-members alike. For example, foundation fee schedules have been published in the regular publications of the defendant societies. (*See, e.g.*, Exhibits PS-1 and MS-14 to Plaintiff's First Request for Admissions; Maricopa Society's Admissions Nos. 60, 101, 102, 103, 117, 172, 173, 197; Maricopa Foundation's Admissions Nos. 57, 58, 169, 176; Pima Foundation's Admissions Nos. 57, 58, 346, 350, 356, 365, 366, 368, 375, 402, 409; Affidavit of Anthony D. Mitten dated December 11, 1978, ¶2.)

18. The Maricopa Foundation has sent the Pima Foundation copies of fee schedules adopted by the Maricopa Foundation, and the Pima Foundation has subsequently adopted those fee schedules. (*See, e.g.*, Gerdenics Deposition, p. 60; Exhibits PF-132, PF-135, PF-148, PF-151 and PF-154 to Plaintiff's First Request for Admissions; Maricopa Foundation's Admissions Nos. 63, 170, 171, 186; Mitten Deposition, Vol. II pp. 47-48, Exhibit 53; Pima Foundation's Admissions Nos. 63, 358, 359, 361, 362.)

19. Doctors' prices have a direct and substantial effect on payments made and premiums charged for health insurance. (*See, e.g.*, Affidavit of William R. DeWaal, attached as Exhibit 3 to the Statement of Undisputed Facts Supporting Plaintiff's Motion for Partial Summary Judgment on the Issue of Subject Matter Jurisdiction (hereinafter "DeWaal Affidavit"), Exhibits B-2 through B-7, B-9, B-16 and B-17; Maricopa Foundation's Admissions Nos. 143, 224, Mitten Deposition, Vol. I pp. 60-64, Vol. II pp. 6-10, Exhibits 20, 21, 32, 33; Finley Affidavit ¶21.)

20. Defendant foundations have endorsed certain health insurance plans (hereinafter referred to as Foundation Plans) which are underwritten by private insurers and meet certain "minimum standards" formulated by defendents. (*See e.g.*, Affidavit of Roger Beck, attached as Exhibit A to Statement of Undisputed Facts Supporting Plaintiff's Motion for Partial Summary Judgment on the Issue of Subject

Matter Jurisdiction (hereinafter "Beck Affidavit"), Exhibits A-3, A-4, A-5, and A-9; DeWaal Affidavit, Exhibits B-6, B-14, B-15, B-17, B-26 and B-27; Gerdenics Deposition, pp. 27-28, Exhibit 48; Mitten Deposition, Vol. I pp. 19-23; Exhibit MF-64 to Plaintiff's First Request for Admissions; Maricopa Foundation's Admissions Nos. 6, 7; Pima Foundation's Admissions Nos. 6, 7.)

21. Defendants' minimum standards for foundation plans include, among other things, coverage of a wide range of services, goods and equipment sold by doctors. (*See e.g.*, Gerdenics Deposition, pp. 110-112, 117, Exhibit 48, §§ II through IV; Exhibit MF-64 to Plaintiff's First Request for Admissions, §§ II through IV; Beck Affidavit, Exhibit A-5, DeWaal Affidavit, Exhibits B-24, B-25, B-26 and B-27; Maricopa Foundation's Admissions No. 9; Pima Foundation's Admissions No. 9).

22. Defendant foundations have made agreements with certain insurers that require the insurers to pay for services, goods and products sold by doctors to foundation policyholders at the prices set by the foundation fee schedules. (*See, e.g.*, Gerdenics Deposition, pp. 22-24, 110-112, Exhibits 5, 6; Beck Affidavit, Exhibits A-2, A-3, A-4 and A-9; DeWaal Affidavit, Exhibits B-1, B-2, B-14, B-15, B-18, B-19 and B-29; Mitten Deposition, Vol. I pp. 21-23, Exhibit 13; Maricopa Foundation's Admissions Nos. 10, 11, 12; Pima Foundation's Admissions Nos. 10, 11, 12.)

23. The prices set by the foundation fee schedules have a direct and substantial effect on payments made and premiums charged for foundation plans. (*See, e.g.*, DeWaal Affidavit, Exhibits B-2 through B-7, B-9 and B-17; Mitten Deposition, Vol. I pp. 60-64, Vol. II pp. 6-10, Exhibits 20, 21, 32, 33; Maricopa Society's Admissions Nos. 146, 147, 188; Maricopa Foundation's Admissions Nos. 143, 188, 224; *See* Finley Affidavit ¶21.)

24. Defendants have provided advance notice of expected increases in foundation fee schedules to insurers that underwrite foundation plans. (*See, e.g.*, Exhibits MF-92, MF-96 and MF-98 to Plaintiff's First Request for Admissions; DeWaal Affidavit, Exhibit B-9; Maricopa Foundation's Admissions Nos. 61, 155, 163, 220, 223, 236; Mitten Deposition, Vol. I pp. 22-25, 51-62, Exhibits 14-18, 22, 59; Pima Foundation's Admissions No. 61.)

25. Foundations members agree to accept the payment allowed by the foundation fee schedule as full compensation on claims assigned to them by foundation policyholders. (*See, e.g.*, Exhibits PF-123, MF-112 through MF-118, MF-64, § I, ¶10, to Plaintiff's First Request for Admissions; Maricopa Foundation's Admissions No. 14; Mitten Deposition, Vol. I p. 110; Affidavit of Anthony D. Mitten dated November 17, 1978, ¶4; Pima Foundation's Admissions No. 14; Gerdenics Deposition Exhibit 48, § I, ¶3; Finley Affidavit ¶16; Pima Foundation's Opposition, at p. 3 ((The Pima Foundation) sets maximum rates for various categories of covered health services.))

26. Unless a foundation policyholder has assigned his or her benefits under a foundation plan in advance, foundation members are not obligated to accept the payments allowed by the foundation fee schedule as full payment for services to that foundation policyholder. (*See, e.g.*, Exhibits MF-64, § I, ¶10, and PF-126 to Plaintiff's First Request for Admissions; Gerdenics Deposition Exhibit 48, § I, ¶8; Maricopa Foundation's Admissions Nos. 14, 16; Pima Foundation's Admissions Nos. 14, 16.)

27. Foundation members have submitted assigned claims for services, goods or products sold to foundation policyholders directly to the foundations and have received payment on those claims directly from the foundations. (*See, e.g.*, Gerdenics Deposition, pp. 112-113, Exhibit 48, § I, ¶4; Exhibit MF-64 § I, ¶6, to Plaintiff's First Request for

Admissions; DeWaal Affidavit, Exhibit B-28, pp. 16-19; Maricopa Foundation's Admissions Nos. 64, 65, 66; Mitten Deposition, Vol. I p. 45; Finley Affidavit ¶9(b); Pima Foundation's Admissions Nos. 64, 65, 66.)

28. Doctors' prices for services, goods and products sold to foundation policyholders have been reviewed by foundation members. (*See, e.g.*, Gerdenics Deposition, pp. 115-116, Exhibits 48, 49; DeWaal Affidavit, Exhibit B-28, pp. 16-19; Maricopa Foundation's Admissions Nos. 70, 71; Finley Affidavit ¶9(b)).

29. The uniform claim form used by defendants has called for the doctor's usual fee for services, goods or products sold to foundation policyholders even if that fee exceeded the price set by the foundation fee schedule. (*See, e.g.*, Gerdenics Deposition, p. 113; Exhibit PF-125 to Plaintiff's First Request for Admissions; Maricopa Foundation's Admissions No. 69; Mitten Deposition, Vol. II pp. 85-86; Pima Foundation's Admissions No. 69.)

30. The foundations' participating and cooperating members have periodically executed applications for foundation membership. (*See, e.g.*, Gerdenics Deposition, pp. 27-28, Exhibit 46; Exhibits PF-123 and MF-112 through MF-118 to Plaintiff's First Request for Admissions; Mitten Deposition, Vol. II pp. 49-50, Exhibit 55; Maricopa Foundation's Admissions No. 13.)

31. Applications for participating and cooperating membership in the foundations have contained an agreement that the foundation member will be bound by the foundation fee schedule. (*See, e.g.*, Gerdenics Deposition, pp. 27-28, Exhibit 46, ¶2; Exhibits PF-123 and MF-112 through MF-118 to Plaintiff's First Request for Admissions; Mitten Deposition Exhibit 55, ¶5; Maricopa Foundation's Admissions No. 14; Pima Foundation's Admissions No. 14.)

32. The defendant societies founded the defendant foundations to promote the interests of fee-for-service medicine. (*See, e.g.*, Exhibits MF-27, MF-70, MF-89, MF-90 and MF-95 to Plaintiff's First Request for Admissions; Maricopa Foundation's Admissions No. 91; Pima Foundation's Admissions No. 317.)

33. The members of the board of directors of the Maricopa County Medical Society (hereinafter "Maricopa Society") have automatically become the administrative members of the Maricopa Foundation. (*See, e.g.*, Exhibit MF-122 to Plaintiff's First Request for Admissions, Ch. II, § 2; Mitten Deposition, Exhibit 30, Ch. II, § 2; Maricopa Society's Admissions No. 3; Maricopa Foundation's Admissions No. 3.)

34. The members of the board of directors of the Pima County Medical Society (hereinafter "Pima Society") have automatically become the administrative members of the Pima Foundation. (*See, e.g.*, Gerdenics Deposition, Exhibit 47, Ch. II, § 2.)

35. As administrative members of the foundations, the members of the boards of directors of the defendant societies have elected or appointed the members of the boards of trustees of the defendant foundations. (*See, e.g.*, Exhibits PS-3 through PS-7, MS-2, MS-10 through MS 13 and MF-67 to Plaintiff's First Request for Admissions; Mitten Deposition, Vol. II pp. 11-12, 14, Exhibit 36; Maricopa Society's Admissions Nos. 5, 177, 245, 264, 267, 308; Maricopa Foundation's Admissions Nos. 177, 245, 264, 267, 308; Pima Foundation's Admissions No. 416.)

36. Administrative members have been the only class of members in each defendant foundation having a general voting power. (*See* Exhibit MF-122 to Plaintiff's First Request for Admissions, Ch. II, § 3; Mitten Deposition, Exhibit 30, Ch. II, § 3; Gerdenics Deposition, Exhibit 47, Ch. II, § 3; Maricopa Foundation's Admissions No. 4.)

37. The By-laws of defendant foundations have given participating and cooperating members the right to vote on the adoption of uniform, average or median fee schedules. (*See e.g.*, Gerdenics Deposition, Exhibit 47 (Ch. II, §§ 5, 7; Exhibit MF-122 to Plaintiff's First Request for Admissions, Ch. II, §§ 5, 7; Mitten Deposition, Exhibit 30, Ch. II, §§ 5, 7; Maricopa Foundation's Admissions No. 34. *See also* the By-laws of the Pima Foundation as amended in October, 1978 [attached hereto as Exhibit N], which provide that "Corporate members shall have the right to vote on the adoption of any contract limits for medical services by the Foundation. Adoption of any such schedule for medical services shall be by mail ballot." Exhibit N, Ch. II, § 2; Pima Foundation's Admissions No. 34.)

38. Defendant societies have known and approved of the activities of defendant foundations. (*See, e.g.*, Exhibits PF-134, PF-139, MS-4, MS-5, MS-7, MF-52, MF-80 and MF-119 to Plaintiff's First Request for Admissions; Gerdenics Deposition, Exhibits 50, 51; Mitten Deposition, Vol. I pp. 4-9; Maricopa Society's Admissions Nos. 198, 200, 201, 203, 222, 314; Maricopa Foundation's Admissions Nos. 198, 199, 200, 201, 202, 203, 222.)

39. Over 70 percent of the doctors in Maricopa County have been members of the Maricopa Foundation. (*See, e.g.*, Exhibit MS-1 to Plaintiff's First Request for Admissions.)

40. Over 70 percent of the doctors in Pima County have been members of the Pima Foundation. (*See, e.g.*, Exhibit PF-125 to Plaintiff's First Request for Admissions.)

41. Defendants have received repeated warnings that their use of agreed-upon relative value schedules and conversion factors violates the antitrust laws. (*E.g.*, Exhibits MF-20 through MF-23 to Plaintiff's First Request for Admissions; Maricopa Society's Admissions No. 242.)

DATED this 21st day of December, 1978.

(Signatures omitted in printing.)

EXHIBIT A

(Caption omitted in printing.)

RESPONSE OF DEFENDANT PIMA FOUNDATION FOR MEDICAL CARE TO PLAINTIFF'S FIRST REQUEST FOR ADMISSIONS AND INTERROGATORIES

* * * *

6. Foundation Plans are underwritten by private insurers which are located in the State of Arizona and elsewhere.

The Pima Foundation admits that only some Pima Foundation-endorsed plans are underwritten by private insurers, each such private insurer doing business from a location in Arizona and at least some do business from locations outside Arizona, and states that otherwise it has no information.

7. To obtain your endorsement as a Foundation Plan, a health insurance plan must comply with the minimum standards formulated by the Foundation.

It admits only that it will not endorse a health insurance plan unless it meets certain minimum standards for Foundation-endorsed group insurance programs.

8. Minimum standards for Foundation Plans are approved by the Board of Trustees of the Foundation.

It admits only that minimum standards for Foundation-endorsed health insurance plans are determined and approved by the Board of Trustees and states that it otherwise has no information.

9. Minimum standards for Foundation Plans inculde, among other things, the doctors' services to be covered under Foundation Plans.

It admits only that minimum standards for Foundation-endorsed health insurance plans include a list of medical services for which the insurer is required to provide reimbursement to insured patients, and states that it otherwise has no information.

10. Minimum standards for Foundation Plans include, among other things, the allowable rate of payment for covered services, goods and products sold by doctors to Foundation policyholders.

It admits only that its "minimum standards for Foundation-endorsed programs" includes a maximum reimbursable payment schedule with respect to payments by the insurer to doctors for services provided to patients insured under Foundation-endorsed health insurance plans, and states that it otherwise has no information.

11. The Foundation has entered into agreements with insurers in which the insurer agreed to comply with the Foundation's minimum standards.

It admits only that it has entered into agreements with insurers pursuant to which those insurers agree to write health insurance for certain groups which is not inconsistent with the Foundation's minimum standards referred to above, and states that it has otherwise no information.

12. The Foundation has entered into agreements with insurers that insurers will pay for services, goods and products sold by doctors to Foundation policy holders at prices up to the amount set in the Foundation fee schedule.

It admits only that it has entered into agreements with insurers wherein insurers agree to reimburse doctors for services rendered to patients insured under Foundation-endorsed health insurance plans in accordance with their usual and customary fees charged for such services, but not

to exceed the maximum reimbursable level of compensation set forth in the Foundation's minimum standards referred to above, except at the insurer's discretion, and states that it otherwise has no information.

13. The Foundation's participating and cooperating members execute applications for membership in the Foundation each year.

Denied.

14. Applications for participating and cooperating membership have contained a provision that the Foundation member will be bound by the fee schedules adopted by Foundation members.

It admits only that its membership agreements with its membership have provided that the members agree to be bound during the period of membership with respect to services provided to patients insured under Foundation-endorsed plans to accept a determination by the Foundation consistent with the schedule adopted by the membership for determining the maximum reimbursable payment as full payment of fees for medical services rendered by them to such patients unless the patients refuse to assign benefits to the member or has multiple health insurance coverage, and states that it has otherwise no information.

15. Foundation members agree to accept the payment allowed by the Foundation fee schedule as full compensation on assigned claims for the covered services, goods and products which they sell to Foundation policyholders.

It repeats its response to Statement 14.

16. Unless a Foundation policyholder has assigned his or her benefits under a Foundation Plan in advance, Foundation members are not obligated to accept the payments allowed by the Foundation fee schedule as full payment for services to that Foundation policyholder.

It repeats its response to Statement 14, and further states that pursuant to the minimum standards for Foundation-endorsed group insurance programs, assignment of benefits by insureds to doctors who are Foundation members is automatic.

17. To determine the fee allowed for a doctor's service under a Foundation Plan, one must refer to both a relative value schedule and a unit conversion factor.

It admits only that to determine the maximum reimbursable payment to a doctor for services provided to a patient insured under a Foundation-endorsed health insurance plan, one must refer both to a relative value schedule and a conversion factor, and states that it has otherwise no information.

18. The Foundation selectes the relative value schedule(s) used to determine the fees allowed for doctors' services under Foundation Plans.

It admits only that the Foundation has prepared Relative Value Schedules used to determine the maximum reimbursable levels of compensation payable by the insurer to doctors for services provided to patients insured under Foundation-endorsed health insurance plans, and states that it otherwise has no information.

19. The Foundation has used a relative value schedule prepared by the California Medical Association.

It admits only that Relative Value Schedules prepared and used by the Foundation are based in part upon the 1964 edition of the Relative Value Schedule adopted by the California Medical Association, and states that it has otherwise no information.

20. The California Medical Association no longer revises or publishes a relative value schedule.

No information.

21. The Foundation has used a relative value schedule prepared by the American Society of Anesthesiologists.

It admits only that Relative Value Schedules prepared and used by the Foundation are based in part upon relative value schedules adopted by the American Society Anesthesiologists and states that it has otherwise no information.

22. The American Society of Anesthesiologists no longer revises or publishes a relative value schedule.

No information.

23. The Foundation has used a relative value schedule prepared by the American College of Radiology.

It admits only Relative Value Schedules prepared and used by the Foundation are based in part upon Relative Value Schedules adopted by the American College of Radiology, and states that it has otherwise no information.

24. The American College of Radiology no longer revises or publishes a relative value schedule.

No information.

25. The Foundation has been informed that agencies of the Federal Government which enforce the federal antitrust laws consider the preparation and publication of a relative value schedule to be a violation of the federal antitrust laws.

Denied.

26. The Foundation has been informed that agencies of the Federal Government which enforce the federal antitrust laws consider the use by doctors of a relative value schedule to be a violation of the federal antitrust laws.

Denied.

27. The Foundation has been informed of legal action taken by agencies of the Federal Government against associations of doctors which have revised and published a relative value schedule.

It states that it does not know what is intended to be referred to by this Request for Admission and objects to it as vague and ambiguous.

28. The Foundation has revised relative value schedules.

It admits only that it has revised its Relative Value Schedules, and states that it has otherwise no information.

29. The Maricopa Foundation prepared a relative value schedule for use in Arizona.

It admits that it has prepared Relative Value Schedules for use in Arizona to determine the maximum reimbursable levels of compensation payable by the insurer to doctors for services provided to patients insured under Foundation-endorsed health insurance plans.

30. The Maricopa Foundation prepared a document entitled "Arizona Medical Services Terminology and Descriptive Index."

No knowledge.

31. The Foundation uses the Arizona Medical Services Terminology and Descriptive Index.

Denied.

32. The Foundation has increased unit values used to determine the fees allowed for some doctors' services under Foundation Plans.

It admits that it has in some instances increased and in some instances decreased the unit value used to determine the maximum reimbursable level of compensation payable by the insurer to doctors for services provided to a patient insured under a Foundation-endorsed health insurance plan, and states that it otherwise has no information.

33. The Foundation fee schedule sets the unit conversion factors used to determine the fees allowed for doctors' services under Foundation Plans.

Denied.

34. Foundation members have the power to vote on the unit conversion factors used to determine the fees allowed for doctors' services under Foundation Plans.

It admits that its members have the right to vote on the adoption of maximum reimbursable levels of compensation to doctors providing medical services to patients insured under Foundation-endorsed health insurance plans, including adoption of conversion factors used with Relative Value Schedules for that purpose, and states that it has otherwise no information.

35. Foundation fee schedules are adopted periodically by majority vote of Foundation members.

Denied.

36. Voting on Foundation fee schedules has been conducted by mail ballot.

Denied.

37. The Foundation has polled its members with respect to the fees they usually charge for their services.

Denied.

38. The Foundation has polled its members with respect to the unit conversion factor(s) they use to determine the fees for their services.

Denied.

39. The Foundation has polled its members with respect to the fees to be allowed for doctors' services under Foundation Plans.

Denied.

40. The Foundation has polled its members with respect to the unit conversion factors to be used to determine the fees allowed for doctors' services under Foundation Plans.

Denied.

41. The Foundation has polled its members with respect to the relative value schedule(s) they use.

Denied.

42. The Foundation has polled its members with respect to the relative value schedule(s) they prefer.

Denied.

43. The Foundation has polled its members with respect to the relative value schedule(s) to be used by the Foundation.

Denied.

44. The Foundation has consulted with various groups of doctors with respect to the fees their members usually charge for their services.

It admits that it has requested various professional organizations whose members are doctors to advise it in connection with its determination of maximum reimbursable levels of compensation to doctors providing medical services to patients insured under Foundation-endorsed health insurance plans to be proposed to the Foundation's members for adoption.

45. The Foundation has consulted with various groups of doctors with respect to the unit conversion factor(s) their members use to determine the fees for their services.

It repeats its response to Statement 44.

46. The Foundation has consulted with various groups of doctors with respect to the fees to be allowed for doctors' services under Foundation Plans.

It repeats its response to Statement 44.

47. The Foundation has consulted with various groups of doctors with respect to the unit conversion factor(s) to be used to determine the fees allowed for doctors' services under Foundation Plans.

It repeats its response to Statement 44.

48. The Foundation has consulted with various groups of doctors with respect to the relative value schedule(s) their members use.

It repeats its response to Statement 44.

49. The Foundation has consulted with various groups of doctors with respect to the relative value schedule(s) their members perfer.

It repeats its response to Statement 44.

50. The Foundation has consulted with various groups of doctors with respect to the relative value schedule(s) to be used by the Foundation.

It repeats its response to Statement 44.

51. The Foundation has asked various groups of doctors to poll their members with respect to the fees they usually charge for their services.

It repeats its response to Statement 44.

52. The Foundation has asked various groups of doctors to poll their members with respect to the unit conversion factor(s) they use to determine the fees for their services.

It repeats its response to Statement 44.

53. The Foundation has asked various groups of doctors to poll their members with respect to the fees to be allowed for doctors' services under Foundation Plans.

It repeats its response to Statement 44.

54. The Foundation has used the information obtained from surveys of doctors in preparing Foundation fee schedules.

It admits that it has used information obtained from surveys of doctors to advise it in connection with its determination of maximum reimbursable levels of compensation to doctors providing medical services to patients insured under Foundation-endorsed health insurance plans to be proposed to its members for adoption.

55. The Foundation has sent proposed Foundation fee schedules to Foundation members for their approval.

It repeats its responses to Statements 34 and 36.

56. Foundation fee schedules have been approved by wide margins.

It does not know what is meant by this statement and objects to it as vague and ambiguous.

57. The Foundation has sent copies of adopted Foundation fee schedules to Foundation members.

It admits that it has sent its members lists of conversion factors used by it to determine maximum reimbursable levels of compensation to doctors providing medical services to patients insured under Foundation-endorsed health insurance plans.

58. The Foundation has sent copies of Foundation fee schedules to doctors who are not Foundation members.

It admits that it has sent copies of current Foundation conversion factors used by it to determine maximum reimbursable levels of compensation to doctors providing medical services to patients insured under Foundation-endorsed health insurance plans to non-member doctors who request membership information and applications.

59. The Society has published, circulated or distributed reports on Foundation activities to Society members.

No knowledge.

60. The Society has published, circulated or distributed Foundation fee schedules to Society members.

No knowledge.

61. The Foundation has provided advance notice of expected increases in Foundation fee schedules to insurers that underwrite Foundation Plans.

It admits that its practice is to advise insurers underwriting health insurance plans endorsed by the Foundation in advance of expected changes to maximum reimbursable levels of compensation to doctors providing medical services to patients insured under Foundation-endorsed health insurance plans.

62. The Foundation has revised its minimum standards to require the coverage of additional doctors' services.

It admits that it has on occasion revised its "minimum standards for Foundation-endorsed group insurance plans," and that those revisions sometime require insurance for additional medical procedures.

63. The Maricopa Foundation has sent the Pima Foundation copies of fee schedules adopted by the Maricopa Foundation.

it admits that it has received from the Maricopa Foundation conversion factors used by the Maricopa Foundation to determine maximum reimbursable levels of compensation to doctors providing medical services to patients insured under Maricopa Foundation-endorsed health insurance plans.

64. The Foundation has administered the review and payment of claims submitted by Foundation policyholders.

It admits only that with respect to some health insurance plans endorsed by it, it has administered both peer review and claims payments on behalf of the insurer.

65. Foundation members submit assigned claims for services, goods or products sold to Foundation policyholders directly to the Foundation.

It admits that with respect to some health insurance plans endorsed by it, its members may submit assigned claims for doctors' services provided patients insured under those plans to it.

66. Foundation members receive payment of assigned claims for services, goods or products sold to Foundation policyholders directly from the Foundation.

It admits only that with respect to some health insurance plans endorsed by it, it writes drafts on the insurer's account as agent of the insurer to pay assigned claims from participating and cooperating members of the Foundation. It admits only that its members are assigned payment on some Foundation-endorsed health insurance policies and that it has supplied to members a preferred claim form for their use.

67. Foundation members submit assigned claims for services, goods or products sold to Foundation policyholders on uniform claim forms provided by the Foundation.

It admits that its members are assigned payments on some Foundation-endorsed health insurance policies and it has supplied to members a preferred claim form for their use.

68. The Maricopa Foundation and Pima Foundation use the same uniform claim form.

Denied.

69. The uniform claim form used by the Foundation calls for the doctor's usual fee for the service(s), good(s) or product(s) sold to Foundation policyholders.

It admits only that the claim forms approved for use by its members have spaces for setting forth the usual and customary fee they have billed to the patient.

70. Foundation members review claims submitted under Foundation Plans to determine the necessity of doctors' services to Foundation policyholders.

It admits only that its peer review function is performed with respect to claims submitted by the insurers to it for reimbursement for services performed by them on Foundation-insured patients to determine if those services were medically necessary or appropriate.

71. Foundation members review claims submitted under Foundation Plans to determine the payment(s) allowed for doctors' services to Foundation policyholders.

It admits that its members review claims submitted for services performed on patients insured under Foundation-approved plans to determine if the services were medically necessary or appropriate and if they were adequately described in the claim.

72. Approximately five per cent of Foundation members charge less than the maximum fee allowed for their services to Foundation policyholders.

No knowledge.

73. Criteria for the review of doctors' services to Foundation policyholders have been prepared by doctors who specialize in those services.

Denied.

74. The Foundation charges the insurers that underwrite Foundation Plans a service fee for the review and processing of claims.

It admits only that it charges insurers that underwrite Foundation-endorsed health insurance plans a fee when it provides peer review and claims process service for the insurer.

75. The Maricopa Foundation and the Pima Foundation have cooperated in the review and processing of claims on certain Foundation Plans, including the State of Arizona Plan.

It admits that with respect to some health insurance plans endorsed by it, it was engaged by the Maricopa Foundation to perform peer review and claims processing service as an agent of the Maricopa Foundation for the insurer with respect to claims submitted for services performed by doctors in Pima County.

76. In August, 1975, the Maricopa Foundation was paying the salary of at least one employee of the Pima Foundation.

It admits only that for a time including August, 1975, it was paid by the Maricopa Foundation the salary of at least one Pima Foundation employee engaged in the activities described in the response to Statement 75.

77. You do not underwrite the actuarial risk of Foundation Plans.

Admitted, as to it.

78. You do not indemnify Foundation policyholders for the cost of services covered by Foundation Plans.

It admits only that its members agree to accept as payment in full of their bills to patients insured under Foundation-endorsed medical insurance plans the maximum reimbursable levels of compensation for medical services provided those patients if those maximum reimbursable levels of compensation are less than their bills, and it states that the doctors who are not members are not so bound.

79. You have not applied to the Director of Insurance of the State of Arizona for a certificate of authority to transact insurance in the State of Arizona pursuant to A.R.S. Section 20-216.

Admitted.

80. You have not been issued a certificate of authority to transact insurance in the State of Arizona pursuant to A.R.S. Section 20-216.

Admitted.

81. You have not applied to the Director of Insurace of the State of Arizona for a license to act as an agent, general agent, broker or solicitor pursuant to A.R.S. Section 20-287, 20-290, 20-291 or 20-295.

Admitted.

82. You have not been issued a license to act as an agent, general agent, broker or solicitor pursuant to A.R.S. Section 20-287, 20-290, 20-291 or 20-295.

Admitted.

86. You have not been issued a certificate of authority to establish or operate a health care services organization pursuant to A.R.S. Section 20-1051 or 20-1052.

Admitted.

* * * *

STATEMENTS TO BE ADMITTED BY DEFENDANTS PIMA SOCIETY AND PIMA FOUNDATION

316. The Foundation was founded in or about February, 1971.

Admitted.

317. The Foundation was founded to promote the practice of medicine on a fee for service basis in the area of Pima County, Arizona.

Admitted.

318. On or about March 1, 1971, the Foundation's Fee Schedule Committee agreed to use the 1969 edition of the California Relative Value Schedule to determine fees allowed for doctors' services under Foundation Plans.

Admitted.

319. In or about March, 1971, the Chairman of the Foundation's Fee Schedule Committee asked various groups of doctors if the Foundation's use of the 1969 edition of the California Relative Value Shedule was agreeable to their members.

Admitted.

320. In or about March, 1971, the Chairman of the Foundation's Fee Schedule Committee asked various groups of doctors what unit conversion factors their members wanted for the Foundation fee schedule.

Admitted.

321. On or about March 15, 1971, a group of Tucson anesthesiologists reported to the Foundation that its members were using the 1970 edition of the relative value schedule prepared by the American Society of Anesthesiologists.

Admitted.

322. In or about March and April of 1971, a group of Tucson anesthesiologists suggested that the Foundation use the 1970 edition of the relative value schedule prepared by the American Society of Anesthesiologists with a conversion factor of 8 for anesthesiology services.

Admitted.

323. After April of 1971, the Foundation used the 1970 edition of the relative value schedule prepared by the American Society of Anesthesiologists to determine allowable fees for anesthesiology services under Foundation Plans.

Admitted.

324. On or about March 17, 1971, the Tucson Psychiatric Society reported to the Foundation that its members were using the fee schedule adopted by the Industrial Commission of Arizona.

Admitted.

325. On or about April 6, 1971, the Chairman of the Foundation's Fee Schedule Committee met with members of the Tucson Psychiatric Society to discuss the Foundation fee schedule.

No information.

326. On or about March 18, 1971, a group of Tucson urologists recommended that the Foundation use a unit conversion factor of 27.5 with the 1969 edition of the California Relative Value Schedule.

Admitted.

327. On or about May 4, 1971, a group of Tucson urologists recommended to the Foundation that the relative value schedule prepared by the American Urologists Association (AUA) be used to determine allowable fees for urological services under Foundation Plans.

Admitted.

328. On or about March 23, 1971, a group of Tucson ophthalmologists reported to the Foundation that they had agreed to accept the 1969 edition of the California Relative Value Schedule with unit conversion factors of $25.00 for surgery and .50 for medicine.

Admitted.

329. On or about April 12, 1971, a group of Tucson neurologists reported to the Foundation that its members were using the 1969 edition of the California Relative Value Schedule with a conversion factor of 26.

Admitted.

330. On or about April 19, 1971, a group of Tucson orthopedic surgeons reported to the Foundation that they would accept the 1969 edition of the California Relative Value Schedule.

Admitted.

331. On or about April 22, 1971, a group of Tucson radiologists reported to the foundation that its members were using the 1969 edition of the relative value schedule prepared by the American College of Radiology with a unit conversion factor of 6.

Admitted.

332. On or about April 22, 1971, a group of Tucson radiologists reported to the Foundation their acceptance of the Foundation's proposed conversion factor of 6.5 for radiological services.

Admitted.

333. On or about April 22, 1971, the Southern Arizona Chapter of the American Academy of General Practice informed the Foundation that its members had agreed to use the 1969 California Relative Value Schedule.

Admitted.

334. On or about May 7, 1971, the agreement of Tucson internists to use the 1969 edition of the California Relative Value Schedule with a conversion factor of .75 for medicine was reported to the Foundation.

Admitted.

335. In or about June, 1971, the Tucson Psychiatric Society reported to the Foundation that its members had agreed to the use of the 1969 edition of the California Relative Value Schedule with a conversion factor of .75.

Admitted.

336. In or about June, 1971, the Tucson Psychiatric Society suggested to the Foundation that a conversion factor of .775 would be appropriate by the fall of 1971.

Admitted.

337. On or about October 25, 1971, the Foundation's minimum standards became effective.

Admitted.

338. On or about October 25, 1971, the Foundation's first fee schedule became effective.

Admitted.

339. On or about June 5, 1973, the Foundation's President was a guest speaker at a meeting of the Tucson Psychiatric Society.

No information.

340. On or about June 5, 1973, the Foundation's President asked members of the Tucson Psychiatric Society to inform the Foundation of the fees and coverage for psychiatric services which they considered desirable.

No information.

341. Beginning on or about June 5, 1973, representatives of the Foundation consulted with representatives of the Tucson Psychiatric Society concerning coverage and fees for psychiatric services.

No information.

342. In or about 1973, the Foundation adopted the Maricopa Foundation's fee schedule for covered psychiatric services.

Denied.

343. On or about August 29, 1973, the Foundation's Fee Schedule Committee met to discuss possible increases in the Foundation fee schedule.

Admitted.

344. The Foundation fee schedule effective in 1973 included unit conversion factors of:

(a) 8 for medicine;
(b) 7 for surgery;
(c) 5.50 for laboratory;
(d) 8 for anesthesiology.
(e) 7 for radiology.

Admitted.

345. In or about December, 1973, the Foundation prepared a proposed fee schedule for 1974.

Admitted.

346. In or about December, 1973, the Foundation sent a proposed Foundation fee schedule for 1974 to Foundation members for approval.

Admitted.

347. By about January 7, 1974, most Foundation members had approved the Foundation fee schedule for 1974.

Admitted.

348. By February 12, 1974, the Foundation had adopted the Foundation fee schedule for 1974.

Admitted.

349. The Foundation fee schedule for 1974 included unit conversion factors of:

(a) 8.50 for medicine;
(b) 7.50 for surgery;
(c) 5.70 for laboratory;
(d) 8.50 for anesthesiology;
(e) 7.50 for radiology with a professional component of 1.70.

Admitted.

350. By February 12, 1974, the Foundation had mailed copies of the Foundation fee schedule for 1974 to Foundation members.

Admitted.

351. In or about August, 1974, an article describing the Foundation was published in the *Sombrero*.

No information.

352. In or about August, 1974, the *Sombrero* reported that the Foundation fee schedule was based upon the 1964 edition of the California Relative Value Schedule.

No information.

353. In or about August, 1974, the *Sombrero* published the Foundation fee schedule for 1974.

No information.

354. The *Sombrero* is a regular publication of the Society.

No information.

355. The *Sombrero* is published, circulated or distributed to Society members.

No information.

356. On or about October 24, 1974, the Chairman of the Foundation's Fee Schedule Committee sent to Foundation members the fee schedule adopted by the Maricopa Foundation effective November 1, 1974.

Admitted.

357. On or about October 24, 1974 the Chairman of the Foundation's Fee Schedule Committee notified Foundation members that the fee schedule adopted by the Maricopa Foundation effective November 1, 1974 had also been recommended to the Industrial Commission of Arizona.

Admitted.

358. On or about October 24, 1974, the Chairman of the Foundation's Fee Schedule Committee notified Foundation members that the fee schedule adopted by the Maricopa Foundation effective November 1, 1974 could be adopted as the Pima Foundation fee schedule if the Foundation members signed the enclosed approval form.

Admitted.

359. By approximately December 9, 1974, Foundation members had approved the fee schedule sent to them by the Chairman of the Foundation's Fee Schedule Committee on or about October 24, 1974.

Admitted.

360. On or about January 30, 1975, the Foundation polled Foundation members concerning the Foundation fee schedule for 1975.

Admitted.

361. The Foundation fee schedule for 1975 coincided exactly with the fee schedule adopted by the Maricopa Foundation for 1975.

Admitted.

362. By approximately February 11, 1975 Foundation members had approved the 1975 fee schedule of the Maricopa Foundation as the Pima Foundation fee schedule for 1975.

Admitted.

363. The Foundation fee schedule for 1975 was adopted by a vote of approximately 119 to 9.

Admitted.

364. The Foundation fee schedule for 1975 included unit conversion factors of:

(a) 10 for medicine;
(b) 8.50 for surgery;
(c) 6.50 for laboratory;
(d) 10 for anesthesiology;
(e) 7.50 for radiology with a professional component of 1.70.

Admitted.

365. On or about April 2, 1976, the Foundation sent Foundation members copies of a proposed fee schedule for pediatric services.

Admitted.

366. The Foundation's proposed fee schedule for pediatric services was based on usual or customary doctors' fees for pediatric services in the Pima County area.

Admitted.

367. On or about April 2, 1975, the Vice President of the Foundation notified Foundation members of Foundation coverage of preventative health services under a Foundation Plan.

Admitted.

368. On or about April 2, 1975, the Vice President of the Foundation sent Foundation members a fee schedule to be used for preventative health services.

Admitted.

369. On or about June 9, 1975, the Foundation's Board of Trustees agreed not to approve Foundation Plans underwritten by Blue Shield of Arizona if Blue Shield also submitted bids for indemnity insurance or health maintenance organization plans to the same prospective subscriber.

Admitted: that such action has since been rescinded.

370. Until about July 1, 1975, the principal place of business of the Foundation and the principal place of business of the Society were located in the same building in Tucson, Arizona.

Admitted.

371. In or about September, 1975, the Foundation employed an Executive Director who had employment experience with the California Medical Association and the Medical Care Foundation of Sacramento.

Admitted.

372. On or about September 1, 1975, the *Sombrero* published the Foundation fee schedule.

No information.

373. In or about September, 1975, approximately 75 percent of the doctors practicing in Pima County, Arizona were members of the Foundation.

No information.

374. In or about November, 1975, approximately 80 percent of the doctors practicing in Pima County, Arizona were members of the Foundation.

No information.

375. In or about November, 1975, the Foundation sent copies of the Foundation fee schedule to Foundation members.

Admitted.

376. Beginning about November 12, 1975, the Foundation reviewed and paid claims for doctors' fees under Foundation Plans written by Blue Cross and Blue Shield of Arizona, Pacific Mutual Insurance Company and Connecticut General Insurance Company.

Denied.

377. On or about November 18, 1975, the Society executed a Memorandum of Understanding with the Foundation and Blue Cross and Blue Shield of Arizona with respect to the Society's group insurance trust.

Denied.

378. On or about November 26, 1975, the Foundation received a fee schedule prepared by the Foundation for Medical Care of Sacramento, California.

Admitted.

379. On or about January 9, 1976, the Chairman of the Foundation's Fee Schedule Committee sent a proposed Foundation fee schedule for 1976 to the Foundation's Board of Trustees.

Admitted.

380. On or about January 10, 1976, a representative of the Foundation attended a meeting of the Board of Directors of the Arizona Medical Association at which the President of the Maricopa Foundation described the Maricopa Foundation's development of a relative value schedule for Arizona doctors.

No information.

381. On or about January 12, 1976, the Foundation's Board of Trustees appointed certain doctors to a Minimum Standards Committee to update the Foundation's minimum standards.

Admitted.

382. On or about January 12, 1976, the Foundation's Board of Trustees approved a recommended Foundation fee schedule for 1976.

Admitted.

383. On or about January 27, 1976, the Society's Board of Directors adjourned its regular meeting and thereafter convened a meeting as administrative members of the Foundation.

No information.

384. On or about January 27, 1976, the Society's Board of Directors approved a slate of officers and by-law amendments for the Foundation.

No information.

385. On or about February 9, 1976, the Foundation's Board of Trustees disbanded the Foundation's Nominations Committee, Fee Schedule Committee and Minimum Standards Committee.

Admitted.

386. On or about February 9, 1976, the Foundations Board of Trustees directed that the Foundation's Executive Comittee act in the capacity of the Nominations Committee, Fee Schedule Committee and Minimum Standards Committee.

Admitted.

387. On or about February 10, 1976, annual premiums on Foundation Plans totalled approximately $576,304.

Admitted.

388. On or about April 8, 1976, the Foundation agreed to perform certain administrative services for the Maricopa Foundation with respect to the State of Arizona Plan.

Admitted.

389. On or about April 12, 1976, the Foundation's Board of Trustees agreed to retain the Foundation fee schedule for 1975 until an expected 20 percent increase in indemnity insurance premiums occurred.

Denied.

390. On or about April 12, 1976, the Foundation's Board of Trustees agreed to review the Foundation fee schedule in May, 1976.

Admitted.

391. In or about April, 1976, the *Sombrero* announced that the Foundation would maintain its 1975 fee schedule through May, 1976.

No information.

392. In or about April, 1976, the *Sombrero* announced that in May, 1976 the Foundation would, as usual, conduct a study to determine the new Foundation fee schedule.

No information.

393. On or about April 12, 1976, the Foundation's Board of Trustees established a Fee Committee.

Admitted.

394. On or about April 12, 1976, the Foundation's Board of Trustees discussed the suggestion of the Maricopa Foundation that the Pima Foundation use the same fee schedule as that adopted by the Maricopa Foundation.

Denied.

395. In or about April, 1976, two representatives of the Foundation attended a meeting in Oakland, California concerning activities of foundations for medical care.

Admitted.

396. On or about May 10, 1976, the Chairman of the Foundation's Fee Schedule Committee presented a proposed Foundation fee schedule for 1976 to the Foundation's Board of Trustees.

Admitted.

397. On or about May 10, 1976, the Foundation adopted the uniform claim form used by the Maricopa Foundation.

No information.

398. On or about May 10, 1976, the Foundation's Board of Trustees decided to use the Foundation's fee schedule for 1976 with an increase in the unit conversion factor for radiology to 8.

Admitted.

399. On or about May 10, 1976, the Foundation's Board of Trustees decided to increase the unit value used by the Foundation for an office visit from 1.0 to 1.3.

Admitted.

400. On or about May 10, 1976, the Foundation's Board of Trustees decided to begin work on the Foundation's fee schedule for 1977 by November of 1976.

Admitted.

401. On or about May 12, 1976, the Foundation's Executive Director sent local counsel for the Foundation the names of two antitrust lawyers.

Admitted.

402. On or about May 17, 1976, the Foundation's Board of Trustees sent Foundation members the proposed Foundation fee schedule for 1976 with an enclosed mail ballot for approval of that schedule.

Admitted.

403. By about June 14, 1976, Foundation members approved the Foundation fee schedule for 1976 by a vote of approximately 262 to 24.

Admitted.

404. On or about October 7, 1976, the Foundation's Minimum Standards Committee presented recommendations for revisions in the minimum standards to the Foundation's Board of Trustees.

Admitted.

405. On or about October 11, 1976, the Foundation's Board of Trustees accepted the report of the Chairman of the Minimum Standards Committee.

Admitted.

406. On or about October 11, 1976, the Foundation's Board of Trustees approved the changes and additions in the Foundation's minimum standards recommended by the Chairman of the Foundation's Minimum Standards Committee.

Admitted.

407. On or about October 7, 1976, the Chairman of the Foundation's Fee Schedule Committee presented a proposed Foundation fee schedule for 1977 to the Foundation's Board of Trustees.

Admitted.

408. On or about October 11, 1976, the Foundation's Board of Trustees approved the proposed Foundation fee schedule for 1977 which was recommended to the Board by the Chairman of the Foundation's Fee Schedule Committee.

Admitted.

409. On or about October 11, 1976, the Foundation's Board of Trustees sent Foundation members the proposed Foundation fee schedule for 1977.

Admitted.

410. On or about October 11, 1976, the Foundation's Board of Trustees notified Foundation members that the unit value used by the Foundation for an office visit had been increased from 1.0 to 1.3.

Admitted.

411. On or about October 18, 1976, the Foundation sent the proposed Foundation fee schedule for 1977 and revisions in the Foundation's minimum standards to Blue Shield of Arizona.

No information.

412. By about November 8, 1976, Foundation members approved the Foundation fee schedule for 1977 by a vote of approximately 178 to 10.

Admitted.

413. The Foundation fee schedule for 1977 includes unit conversion factors of:

(a) 11 for medicine;

(b) 9.50 for surgery;

(c) 7 for laboratory;

(d) 12 for anesthesiology;

(e) 8.50 for radiology with a professional component of 1.80.

Admitted.

414. On or about November 8, 1976, the Tucson Pediatric Society agreed to a fee schedule for well baby care proposed by the Foundation.

Admitted.

415. The Foundation fee schedule proposed in 1976 for well-baby care consisted of a conversion factor of 11.

Denied.

416. On or about November 23, 1976, the Society's Board of Directors approved the election of members of the Foundation's Board of Trustees.

Admitted.

417. On or about January 1, 1977, the Foundation's revised minimum standards became effective.

Admitted.

418. On or about January 21, 1977, the Foundation's Board of Trustees directed the Foundation's Peer Review Committee to reimburse fees for office visits according to the unit values provided in the 1974 edition of the California Relative Value Schedule.

Denied.

419. On or about November 21, 1977, Foundation's Fee Schedule Committee informed the Foundation's Board of Trustees that the Foundation fee schedule was lower than the fee schedules of the Maricopa Foundation and the Industrial Commission of Arizona.

Admitted.

420. On or about November 21, 1977, the Foundation's Board of Trustee directed that a Foundation committee study the Foundation fee schedule.

Admitted.

421. On or about November 21, 1977, the Foundation's Board of Trustees directed that a committee report to the Board by December 12, 1977 concerning a revised Foundation fee schedule for 1978.

Admitted.

422. On or about December 12, 1977, the Chairman of the Foundation's Fee Schedule Committee presented a proposed Foundation fee schedule for 1978 to the Foundation's Board of Trustees.

Admitted.

423. On or about December 13, 1977, the Foundation's Board of Trustees sent a proposed Foundation fee schedule for 1978 to Foundation members with an enclosed mail ballot for approval of that fee schedule.

Admitted.

424. On or about December 13, 1977, the Foundation's Board of Trustees reminded Foundation members that the unit value used by the Foundation for an office visit was 1.3.

Admitted.

425. On or about January 16, 1978, the Chairman of the Foundation's Fee Schedule Committee informed the Foundation's Board of Trustees that Foundation members had approved the Foundation fee schedule for 1978.

Admitted.

426. The Foundation fee schedule for 1978 includes unit conversion factors of:

(a) 11.75 for medicine;
(b) 10.00 for surgery;
(c) 7.40 for laboratory;

(d) 13.00 for anesthesiology.

(e) 9.00 for radiology with a professional component of 2.00.

Admitted.

427. On or about January 31, 1978, the Society's Board of Directors elected a new slate of members of the Foundation's Board of Trustees.

Denied.

428. The Society is an association of doctors in Pima County, Arizona.

Admitted.

* * * *

EXHIBIT B

(Caption omitted in printing.)

PLAINTIFF'S FIRST
REQUEST FOR ADMISSIONS
AND INTERROGATORIES
AND RESPONSES OF DEFENDANT
MARICOPA FOUNDATION FOR
MEDICAL CARE

* * * *

STATEMENTS TO BE ADMITTED BY ALL DEFENDANTS

1. The Foundation has four classes of membership: administrative, participating, cooperating and PSRC.

The Maricopa Foundation only admits that the Maricopa Foundation has four classes of membership: administrative, participating, cooperating and health care institution participating members and states it has no information sufficient to admit or deny this statement with respect to Pima Foundation.

2. The members of the Board of Directors of the Society are elected by the members of the Society.

The Maricopa Foundation has no information sufficient to admit or deny the truth or falsity of this statement and refers plaintiff to the responses provided by defendants Maricopa Society and Pima Society.

3. The Members of the Board of Directors of the Society automatically become administrative members of the Foundation.

The Maricopa Foundation only admits that, pursuant to the By-Laws of Maricopa Foundation, every person, upon becoming a member of the Board of Directors of the Maricopa Society is entitled to become and, without further

action or proceeding, becomes an administrative member of the Maricopa Foundation and states it has no information sufficient to admit or deny this statement with respect to Pima Foundation.

4. Administrative members are the only class of members in the Foundation having a general voting power.

The Maricopa Foundation only admits that the only class of members of the Maricopa Foundation with the privilege of voting in the Maricopa Foundation is administrative members except that participating and cooperating members have the right to vote on the adoption of maximum reimbursable levels of compensation to doctors providing medical services to patients insured under Maricopa Foundation-endorsed health insurance plans and that the Board of Trustees of Maricopa Foundation has full and sole power to control and manage the property and conduct the affairs and business of Maricopa Foundation and have general voting power with respect thereto and states it has no information sufficient to admit or deny this statement with respect to Pima Foundation.

5. As the administrative members of the Foundation, the members of the Board of Directors of the Society elect or appoint the members of the Board of Trustees of the Foundation.

The Maricopa Foundation only admits that the administrative members of the Maricopa Foundation elect the Board of Trustees of the Maricopa Foundation and states it has no information sufficient to admit or deny this statement with respect to Pima Foundation.

6. Foundation Plans are underwritten by private insurers which are located in the State of Arizona and elsewhere.

The Maricopa Foundation only admits that some Maricopa Foundation-endorsed plans are underwritten by private insurers, each such private insurer does business from

a location in Arizona and at least some do business from locations outside Arizona and states it has no information sufficient to admit or deny this statement with respect to Pima Foundation.

7. To obtain your endorsement as a Foundation Plan, a health insurance plan must comply with the minimum standards formulated by the Foundation.

The Maricopa Foundation only admits that it will not endorse a health insurance plan unless it meets minimum standards for foundation-endorsed group insurance programs formulated by Maricopa Foundation or Maricopa Foundation agrees in writing to a modification of those standards.

8. Minimum standards for Foundation Plans are approved by the Board of Trustees of the Foundation.

The Maricopa Foundation only admits that minimum standards for Maricopa Foundation-endorsed health insurance plans are determined and approved by the Board of Trustees of Maricopa Foundation and states it has no information sufficient to admit or deny this statement with respect to Pima Foundation.

9. Minimum standards for Foundation Plans include, among other things, the doctors' services to be covered under Foundation Plans.

The Maricopa Foundation only admits minimum standards for Maricopa Foundation-endorsed health insurance plans include a list of medical services for which the insurer is required to provide reimbursement to insured patients and states it has no information sufficient to admit or deny this statement with respect to Pima Foundation.

10. Minimum standards for Foundation Plans include, among other things, the allowable rate of payment for covered services, goods and products sold by doctors to Foundation policyholders.

The Maricopa Foundation only admits that its "Minimum Standards for Foundation-Endorsed Group Insurance Programs" includes a maximum reimbursable payment schedule with respect to payments by the insurer to doctors for services provided to patients insured under Maricopa Foundation-endorsed health insurance plans and states it has no information sufficient to admit or deny this statement with respect to Pima Foundation.

11. The Foundation has entered into agreements with insurers in which the insurer agreed to comply with the Foundation's minimum standards.

The Maricopa Foundation only admits that is has entered into agreements with insurers pursuant to which those insurers agree to write health insurance for certain groups which is not inconsistent with Maricopa Foundation's "Minimum Standards for Foundation-Endorsed Group Insurance Plans" and states it has no information sufficient to admit or deny this statement with respect to Pima Foundation.

12. The Foundation has entered into agreements with insurers that insurers will pay for services, goods and products sold by doctors to Foundation policy holders at prices up to the amount set in the Foundation fee schedule.

The Maricopa Foundation only admits that it has entered into agreements with insurers wherein insurers agreed to reimburse doctors for services rendered to patients insured under Maricopa Foundation-endorsed health insurance plans in accordance with their usual and customary fees charged for such services but not to exceed the maximum reimbursable level of compensation set forth in the Maricopa Foundation's "Minimum Standards for Foundation-Endorsed Group Insurance Programs" except at the insurer's discretion and states it has no information sufficient to admit or deny this statement with respect to Pima Foundation.

13. The Foundation's participating and cooperating members execute applications for membership in the Foundation each year.

The Maricopa Foundation only admits that the Maricopa Foundation enters membership agreements with its participating and cooperating members annually and states it has no information sufficient to admit or deny this statement with respect to Pima Foundation.

14. Applications for participating and cooperating membership have contained a provision that the Foundation member will be bound by the fee schedules adopted by Foundation members.

The Maricopa Foundation only admits that its membership agreements with its participating and cooperating membership have provided that those members agree to be bound during the period of membership applied for with respect to services provided to patients insured under Maricopa Foundation-endorsed plans to accept a determination by the Maricopa Foundation consistent with the schedule adopted by the membership for determining the maximum reimbursable payment as full payment of fees for medical services rendered by them to such patients unless the patient refused to assign benefits to the member or has multiple health insurance coverage and states it has no information sufficient to admit or deny this statement with respect to Pima Foundation.

15. Foundation members agree to accept the payment allowed by the Foundation fee schedule as full compensation on assigned claims for the covered services, goods and products which they sell to Foundation policyholders.

The Maricopa Foundation repeats its response to statement 14.

16. Unless a Foundation policyholder has assigned his or her benefits under a Foundation Plan in advance, Foundation members are not obligated to accept the payments allowed by the Foundation fee schedule as full payment for services to that Foundation policyholder.

The Maricopa Foundation repeats its response to statement 14 and further states that pursuant to the minimum standards for foundation-endorsed group insurance programs assignment of benefits by insureds to doctors who are foundation members is automatic.

17. To determine the fee allowed for a doctor's service under a Foundation Plan, one must refer to both a relative value schedule and a unit conversion factor.

The Maricopa Foundation only admits that to determine the maximum reimbursable payment to a doctor for services provided to a patient insured under a Maricopa Foundation-endorsed health insurance plan, one must refer both to a relative value schedule and a conversion factor and peer review determines that the services are medically necessary or appropriate and states it has no information sufficient to admit or deny this statement with respect to Pima Foundation.

18. The Foundation selects the relative value schedule(s) used to determine the fees allowed for doctors' services under Foundation Plans.

The Maricopa Foundation only admits that the Maricopa Foundation has prepared relative value schedules used to determine the maximum reimbursable levels of compensation payable by the insurer to doctors for services provided to patients insured under Maricopa Foundation-endorsed health insurance plans and states it has no information sufficient to admit or deny this statement with respect to Pima Foundation.

19 The Foundation has used a relative value schedule prepared by the California Medical Association.

The Maricopa Foundation only admits that relative value chedules prepared and used by Maricopa Foundation are ased in part upon the 1964 edition of the relative value chedule adopted by the California Medical Association and tates it has no information sufficient to admit or deny this tatement with respect to Pima Foundation.

20. The California Medical Association no longer revises r publishes a relative value schedule.

The Maricopa Foundation has no information sufficient o admit or deny the truth or falsity of this statement.

21. The Foundation has used a relative value schedule repared by the American Society of Anesthesiologists.

The Maricopa Foundation only admits that relative value chedules prepared and used by Maricopa Foundation are ased in part upon relative value schedules adopted by the merican Society of Anesthesiologists and states it has no nformation sufficient to admit or deny this statement with espect to Pima Foundation.

22. The American Society of Anesthesiologists no longer evises or publishes a relative value schedule.

The Maricopa Foundation has no information sufficient o admit or deny the truth or falsity of this statement.

23. The Foundation has used a relative value schedule repared by the American College of Radiology.

The Maricopa Foundation only admits that relative value chedules prepared and used by Maricopa Foundation are ased in party upon relative value schedules adopted by the merican College of Radiology and states it has no infor- nation sufficient to admit or deny this statement with espect to Pima Foundation.

24. The American College of Radiology no longer revises r publishes a relative value schedule.

The Maricopa Foundation has no information sufficient o admit or deny the truth or falsity of this statement.

25. The Foundation has been informed that agencies of the Federal Government which enforce the federal antitrust laws consider the preparation and publication of a relative value schedule to be a violation of the federal antitrust laws.

Denied as to Maricopa Foundation. Maricopa Foundation states it has no information sufficient to admit or deny this statement with respect to Pima Foundation.

26. The Foundation has been informed that agencies of the Federal Government which enforce the federal antitrust laws consider the use by doctors of a relative value schedule to be a violation of the federal antitrust laws.

Denied as to Maricopa Foundation. Maricopa Foundation states it has no information sufficient to admit or deny this statement with respect to Pima Foundation.

27. The Foundation has been informed of legal action taken by agencies of the Federal Government against associations of doctors which have revised and published a relative value schedule.

The Maricopa Foundation objects to this statement on the bases that it is vague and ambiguous and beyond the scope of discovery permitted by Rules 26(b) and 36 of the Federal Rules of Civil Procedure.

28. The Foundation has revised relative value schedules.

The Maricopa Foundation only admits that it has revised its relative value schedules and states it has no information sufficient to admit or deny this statement with respect to Pima Foundation.

29. The Maricopa Foundation prepared a relative value schedule for use in Arizona.

The Maricopa Foundation only admits that it has prepared relative value schedules for use in Arizona to determine the maximum reimbursable levels of compensation payable by the insurer to doctors for services provided to patients insured under Maricopa Foundation-endorsed health insurance plans.

30. The Maricopa Foundation prepared a document entitled "Arizona Medical Services Terminology and Descriptive Index."

Denied.

31. The Foundation uses the Arizona Medical Services Terminology and Descriptive Index.

Denied as to Maricopa Foundation. Maricopa Foundation states it has no information sufficient to admit or deny this statement with respect to Pima Foundation.

32. The Foundation has increased unit values used to determine the fees allowed for some doctors' services under Foundation Plans.

The Maricopa Foundation only admits that it has in some instances increased and in some instances decreased the unit value used to determine the maximum reimbursable level of compensation payable by the insurer to doctors for services provided to a patient insured under a Maricopa Foundation-endorsed health insurance plan and states it has no information sufficient to admit or deny this statement with respect to Pima Foundation.

33. The Foundation fee schedule sets the unit conversion factors used to determine the fees allowed for doctors' services under Foundation Plans.

Denied as to Maricopa Foundation. Maricopa Foundation states it has no information sufficient to admit or deny this statement with respect to Pima Foundation.

34. Foundation members have the power to vote on the unit conversion factors used to determine the fees allowed for doctors' services under Foundation Plans.

Maricopa Foundation only admits that its participating and cooperating members have the right to vote on the adoption of maximum reimbursable levels of compensation to doctors providing medical services to patients insured under Maricopa Foundation-endorsed health insurance plans, including adoption of conversion factors used with relative value schedules for that purpose and states it has no information sufficient to admit or deny this statement with respect to Pima Foundation.

35. Foundation fee schedules are adopted periodically by majority vote of Foundation members.

Denied as to Maricopa Foundation. Maricopa Foundation states it has no information sufficient to admit or deny this statement with respect to Pima Foundation. See response to statement 34.

36. Voting on Foundation fee schedules has been conducted by mail ballot.

Denied as to Maricopa Foundation. See response to statement 34. The voting referred to in response to statement 34 has been conducted by mail ballot. Maricopa Foundation states it has no information sufficient to admit or deny this statement with respect to Pima Foundation.

37. The Foundation has polled its members with respect to the fees they usually charge for their services.

The Maricopa Foundation only admits that it has surveyed its members as to their usual and customary fees for medical services and states it has no information sufficient to admit or deny this statement with respect to Pima Foundation.

38. The Foundation has polled its members with respect to the unit conversion factor(s) they use to determine the fees for their services.

The Maricopa Foundation only admits that it has surveyed its members as to what dollar conversion factors would approximate their usual and customary fees for medical services and states it has no information sufficient to admit or deny this statement with respect to Pima Foundation.

39. The Foundation has polled its members with respect to the fees to be allowed for doctors' services under Foundation Plans.

Denied as to Maricopa Foundation. See responses to statements 34 and 36. Maricopa Foundation states it has no information sufficient to admit or deny this statement with respect to Pima Foundation.

40. The Foundation has polled its members with respect to the unit conversion factors to be used to determine the fees allowed for doctors' services under Foundation Plans.

Denied as to Maricopa Foundation. See responses to statements 34 and 36. Maricopa Foundation states it has no information sufficient to admit or deny this statement with respect to Pima Foundation.

41. The Foundation has polled its members with respect to the relative value schedule(s) they use.

The Maricopa Foundation only admits that it has surveyed its members as to what relative value schedule they use for purposes of calculating the conversion factors which would approximate their usual and customary fees for medical services and states it has no information sufficient to admit or deny this statement with respect to Pima Foundation.

42. The Foundation has polled its members with respect to the relative value schedule(s) they prefer.

Denied as to Maricopa Foundation. See response to statement 41 and letters from the Maricopa Foundation to its members dated June 20, 1974, July 5, 1974, May 20, 1975, October 10, 1975 and October 27, 1975, copies of which were produced to plaintiff on April 7, 1978. Maricopa Foundation states it has no information sufficient to admit or deny this statement with respect to Pima Foundation.

43. The Foundation has polled its members with respect to the relative value schedule(s) to be used by the Foundation.

Denied as to Maricopa Foundation. See response to statement 42. Maricopa Foundation states it has no information sufficient to admit or deny this statement with respect to Pima Foundation.

44. The Foundation has consulted with various groups of doctors with respect to the fees their members usually charge for their services.

Maricopa Foundation only admits it has requested various professional organizations whose members are doctors to advise Maricopa Foundation in connection with Maricopa Foundation's determination of maximum reimbursable levels of compensation to doctors providing medical services to patients insured under Maricopa Foundation-endorsed health insurance plans to be proposed to Maricopa Foundation's participating and cooperating members for adoption and states it has no information sufficient to admit or deny this statement with respect to Pima Foundation.

45. The Foundation has consulted with various groups of doctors with respect to the unit conversion factor(s) their members use to determine the fees for their services.

Maricopa Foundation repeats its response to statement 44.

46. The Foundation has consulted with various groups of doctors with respect to the fees to be allowed for doctors' services under Foundation Plans.

Maricopa Foundation repeats its response to statement 44.

47. The Foundation has consulted with various groups of doctors with respect to the unit conversion factor(s) to be used to determine the fees allowed for doctors' services under Foundation Plans.

Maricopa Foundation repeats its response to statement 44.

48. The Foundation has consulted with various groups of doctors with respect to the relative value schedule(s) their members use.

Maricopa Foundation repeats its response to statement 44.

49. The Foundation has consulted with various groups of doctors with respect to the relative value schedule(s) their members prefer.

Maricopa Foundation repeats its response to statement 44.

50. The Foundation has consulted with various groups of doctors with respect to the relative value schedule(s) to be used by the Foundation.

Maricopa Foundation repeats its response to statement 44.

51. The Foundation has asked various groups of doctors to poll their members with respect to the fees they usually charge for their services.

Maricopa Foundation repeats its response to statement 44.

52. The Foundation has asked various groups of doctors to poll their members with respect to the unit conversion factor(s) they use to determine the fees for their services.

Maricopa Foundation repeats its response to statement 44.

53. The Foundation has asked various groups of doctors to poll their members with respect to the fees to be allowed for doctors' services under Foundation Plans.

Maricopa Foundation repeats its response to statement 44.

54. The Foundation has used the information obtained from surveys of doctors in preparing Foundation fee schedules.

The Maricopa Foundation only admits it has used information obtained from surveys of doctors to advise Maricopa Foundation in connection with its determination of maximum reimbursable levels of compensation to doctors providing medical services to patients insured under Maricopa Foundation-endorsed health insurance plans to be proposed to Maricopa Foundation's participating and cooperating members for adoption and states it has no information sufficient to admit or deny this statement with respect to Pima Foundation.

55. The Foundation has sent proposed Foundation fee schedules to Foundation members for their approval.

Maricopa Foundation repeats its responses to statements 34 and 36.

56. Foundation fee schedules have been approved by wide margins.

The Maricopa Foundation objects to this statement on the basis that it is vague and ambiguous.

57. The Foundation has sent copies of adopted Foundation fee schedules to Foundation members.

The Maricopa Foundation only admits that it has sent to its members lists of conversion factors used by it to determine maximum reimbursable levels of compensation to doctors providing medical services to patients insured under Maricopa Foundation-endorsed health insurance plans and states it has no information sufficient to admit or deny this statement with respect to Pima Foundation.

58. The Foundation has sent copies of Foundation fee schedules to doctors who are not Foundation members.

The Maricopa Foundation only admits that it has sent copies of current Maricopa Foundation conversion factors used by it to determine maximum reimbursable levels of compensation to doctors providing medical services to patients insured under Maricopa Foundation-endorsed health insurance plans to non-member doctors who request membership information and applications and states it has no information sufficient to admit or deny this statement with respect to Pima Foundation.

59. The Society has published, circulated or distributed reports on Foundation activities to Society members.

The Maricopa Foundation has no information sufficient to admit or deny the truth or falsity of this statement and refers plaintiff to the responses provided by the Maricopa Society and Pima Society.

60. The Society has published, circulated or distributed Foundation fee schedules to Society members.

The Maricopa Foundation has no information sufficient to admit or deny the truth or falsity of this statement and refers plaintiff to the responses provided by the Maricopa Society and Pima Society.

61. The Foundation has provided advance notice of expected increases in Foundation fee schedules to insurers that underwrite Foundation Plans.

The Maricopa Foundation only admits that its practice is to advise insurers underwriting health insurance plans endorsed by Maricopa Foundation in advance of expected changes to maximum reimbursable levels of compensation to doctors providing medical services to patients insured under Maricopa Foundation-endorsed health insurance plans and states it has no information sufficient to admit or deny this statement with respect to Pima Foundation.

62. The Foundation has revised its minimum standards to require the coverage of additional doctors' services.

The Maricopa Foundation only admits that on occasion it has revised its "Minimum Standards for Foundation-Endorsed Group Insurance Plans" and that those revisions sometimes require insurance for additional medical procedures.

63. The Maricopa Foundation has sent the Pima Foundation copies of fee schedules adopted by the Maricopa Foundation.

The Maricopa Foundation only admits it has sent to Pima Foundation conversion factors used by Maricopa Foundation to determine maximum reimbursable levels of compensation to doctors providing medical services to patients insured and Maricopa Foundation-endorsed health insurance plans.

64. The Foundation has administered the review and payment of claims submitted by Foundation policyholders.

The Maricopa Foundation only admits that with respect to some health insurance plans endorsed by Maricopa Foundation, it has administered both peer review and claims payments on behalf of the insurer and states that it has no information sufficient to admit or deny this statement with respect to Pima Foundation.

65. Foundation members submit assigned claims for services, goods or products sold to Foundation policyholders directly to the Foundation.

Maricopa Foundation only admits that with respect to some health insurance plans endorsed by Maricopa Foundation, its participating and cooperating members may submit assigned claims for doctors services provided to patients insured under those plans to Maricopa Foundation and states it has no information sufficient to admit or deny the statement with respect to Pima Foundation.

66. Foundation members receive payment of assigned claims for services, goods or products sold to Foundation policyholders directly from the Foundation.

Maricopa Foundation only admits that with respect to some health insurance plans endorsed by Maricopa Foundation it writes drafts on the insurer's account as agent of the insurer to pay assigned claims from participating and cooperating members of Maricopa Foundation and states that it has no information sufficient to admit or deny the statement with respect to Pima Foundation.

67. Foundation members submit assigned claims for services, goods or products sold to Foundation policyholders on uniform claim forms provided by the Foundation.

Maricopa Foundation only admits its members are assigned payments on some Maricopa Foundation-endorsed health insurance policies and that it has supplied to members a preferred claim form for their use and states that it is without knowledge sufficient to admit or deny the statements made with respect to Pima Foundation.

68. The Maricopa Foundation and Pima Foundation use the same uniform claim form.

Denied.

69. The uniform claim form used by the Foundation calls for the doctor's usual fee for the service(s), good(s) or product(s) sold to Foundation policyholders.

Maricopa Foundation only admits that the claim forms approved for use by its participating and cooperating members have spaces for setting forth the usual and customary fee they have billed to the patient and states that it is without knowledge sufficient to admit or deny the statement made with respect to Pima Foundation.

70. Foundation members review claims submitted under Foundation Plans to determine the necessity of doctors' services to Foundation policyholders.

The Maricopa Foundation only admits that its peer review function is performed with respect to claims submitted by doctors to Maricopa Foundation for reimbursement for services performed by them on Foundation insured patients to determine if those services were medically necessary or appropriate and states that it is without sufficient knowledge to admit or deny with respect to Pima Foundation.

71. Foundation members review claims submitted under Foundation Plans to determine the payment(s) allowed for doctors' services to Foundation policyholders.

Maricopa Foundation only admits that its members review claims submitted for services performed on patients insured under Foundation plans to determine if those services were medically necessary or appropriate and if they were adequately described in the claim and states it is without knowledge sufficient to admit or deny the statement with respect to Pima Foundation.

72. Approximately five per cent of Foundation members charge less than the maximum fee allowed for their services to Foundation policyholders.

Maricopa Foundation only admits that, depending upon the medical procedure, between approximately five and fifteen percent of its members bill patients less than the maximum reimbursable levels of compensation for medical

services provided to patients insured under Maricopa Foundation-endorsed health insurance plans and states it has no information sufficient to admit or deny this statement with respect to Pima Foundation.

73. Criteria for the review of doctors' services to Foundation policyholders have been prepared by doctors who specialize in those services.

Denied as to Maricopa Foundation. Maricopa Foundation states it has no information sufficient to admit or deny this statement with respect to Pima Foundation.

74. The Foundation charges the insurers that underwrite Foundation Plans a service fee for the review and processing of claims.

The Maricopa Foundation only admits that it charges insurers that underwrite Maricopa Foundation-endorsed health insurance plans a fee when it provides peer review and claims processing service for the insurer and states that it has no information sufficient to admit or deny this statement with respect to Pima Foundation.

75. The Maricopa Foundation and the Pima Foundation have cooperated in the review and processing of claims on certain Foundation Plans, including the State of Arizona Plan.

Maricopa Foundation only admits that with respect to some health insurance plans endorsed by it, Pima Foundation was engaged by Maricopa Foundation to perform peer review and claims processing service as an agent of Maricopa Foundation for the insurer with respect to claims submitted for services performed by doctors in Pima County.

76. In August, 1975, the Maricopa Foundation was paying the salary of at least one employee of the Pima Foundation.

Maricopa Foundation only admits that for a time including August 1975 Maricopa Foundation paid to Pima Foundation the salary of at least one Pima Foundation employee engaged in the activities described in response to statement 75.

77. You do not underwrite the actuarial risk of Foundation Plans.

The Maricopa Foundation only admits this statement to the extent that it applies to the Maricopa Foundation and states it is without information sufficient to admit or deny this statement with respect to Pima Foundation.

78. You do not indemnify Foundation policyholders for the cost of services covered by Foundation Plans.

Maricopa Foundation only admits that its cooperating and participating members agree to accept as payment in full of their bills to patients insured under Maricopa Foundation-endorsed medical health insurance plans the maximum reimbursable levels of compensation for medical services provided to those patients if those maximum reimbursable levels of compensation are less than their bills and states that doctors who are not cooperating or participating members are not so bound and that it is without information sufficient to admit or deny this statement with respect to Pima Foundation.

79. You have not applied to the Director of Insurance of the State of Arizona for a certificate of authority to transact insurance in the State of Arizona pursuant to A.R.S. Section 20-216.

The Maricopa Foundation admits this statement.

80. You have not been issued a certificate of authority to transact insurance in the State of Arizona pursuant to A.R.S. Section 20-216.

The Maricopa Foundation admits this statement.

81. You have not applied to the Director of Insurance of the State of Arizona for a license to act as an agent, general agent, broker or solicitor pursuant to A.R.S. Section 20-287, 20-290, 20-291 or 20-295.

The Maricopa Foundation admits this statement.

82. You have not been issued a license to act as an agent, general agent, broker or solicitor pursuant to A.R.S. Section 20-287, 20-290, 20-291 or 20-295.

The Maricopa Foundation admits this statement.

83. You have not applied to the Director of Insurance of the State of Arizona for a certificate of registration as an insurance administrator pursuant to A.R.S. Section 20-485.12.

Denied.

84. You have not been issued a certificate of registration as an insurance administrator pursuant to A.R.S. Section 20-485.12.

Denied.

85. You have not applied for a certificate of authority to establish or operate a health care services organization pursuant to A.R.S. Section 20-1051 or 20-1052.

The Maricopa Foundation admits this statement.

86. You have not been issued a certificate of authority to establish or operate a health care services organization pursuant to A.R.S. Section 20-1051 or 20-1052.

The Maricopa Foundation admits this statement.

87. The Foundation is a member of the American Association of Foundations for Medical Care.

The Maricopa Foundation admits this statement only to the extent that it applies to the Maricopa Foundation and states it is without sufficient information to admit or deny this statement with respect to Pima Foundation.

88. The Foundation is a member of the American Association of Foundations for Professional Standards Review Organizations.

The Maricopa Foundation denies this statement only to the extent that it applies to the Maricopa Foundation and states it is without sufficient information to admit or deny this statement with respect to Pima Foundation.

* * * *

STATEMENTS TO BE ADMITTED BY DEFENDANTS MARICOPA SOCIETY AND MARICOPA FOUNDATION

90. The Foundation was founded in or about 1969.

Admitted.

91. The Foundation was founded to promote the practice of medicine on a fee for service basis is the State of Arizona.

The Maricopa Foundation only admits that the Maricopa Foundation was founded, *inter alia* to promote the practice of medicine in Maricopa County on a fee for service basis.

92. Between January, 1970 and April, 1970, the Foundation consulted with various groups of doctors with respect to the fees charged by their members for doctors' services.

See response to statement 44.

93. In or about 1970 the Foundation fee schedule included unit conversion factors of:

(a) 7.50 for medicine;
(b) 6.50 for surgery;
(c) 5.00 for laboratory;
(d) 7.50 for anesthesiology.

Maricopa Foundation only admits that the conversion factors used by Maricopa Foundation to calculate maximum reimbursable levels of compensation payable by the insurer to doctors for services provided to patients insured under Maricopa Foundation-endorsed health insurance plans are as stated in statement 93.

94. In or about 1972 the Foundation fee schedule included unit conversion factors of:

(a) 8 for medicine;
(b) 7 for surgery;
(c) 5.50 for laboratory;
(d) 7 for radiology with a professional component of $1.70;
(e) 8 for anesthesiology.

Maricopa Foundation only admits that the conversion factors used by Maricopa Foundation to calculate maximum reimbursable levels of compensation payable by the insurer to doctors for services provided to patients insured under Maricopa Foundation-endorsed health insurance plans are as stated in statement 94.

95. The Foundation fee schedule adopted in or about January, 1974 included unit conversion factors of:

(a) 8.60 for medicine;
(b) 7.50 for surgery;
(c) 5.90 for laboratory;
(d) 7.50 for radiology with a professional component of $1.70;
(e) 8.60 for anesthesiology.

The Maricopa Foundation admits that the following conversion factors were in effect as of January 1, 1974 with respect to Maricopa Foundation-endorsed plans having an effective date on or after January 1, 1974 for use in calculating maximum reimbursable levels of compensation payable by the insurer to doctors for services provided to patients insured under such plans:

(a) $8.60 for medicine, pathology (procedures 8901 through 8925) and anesthesiology (with one risk modifier in anesthesia allowed for emergency cases after 6:00 p.m.);

(b) $7.50 for surgery and radiology (with a professional component of $1.70); and

(c) $5.90 for clinical laboratory.

96. The Foundation fee schedule adopted in or about November, 1974 included unit conversion factors of:

(a) 10 for medicine;
(b) 8.50 for surgery;
(c) 6.50 for laboratory;
(d) 7.50 for radiology with a professional component of $1.70;
(e) 10 for anesthesiology.

The Maricopa Foundation admits that the following conversion factors were in effect as of November 1, 1974 with respect to Maricopa Foundation-endorsed plans having an effective date on or after November 1, 1974 for use in calculating maximum reimbursable levels of compensation payable by the insurer to doctors for services provided to patients insured under such plans:

(a) $10.00 for medicine, pathology (procedures 8901 through 8925) and anesthesiology (with one risk modifier in anesthesia allowed for emergency cases after 6:00 p.m.);

(b) $8.50 for surgery;

(c) $7.50 for radiology with a professional component of $1.70, and;

(d) $6.50 for clinical pathology.

97. Between 1970 and November, 1974, the Foundation fee schedule for medicine increased approximately 33.3 per cent.

Maricopa Foundation only admits that between 1970 and November 1974 its conversion factor applicable to determine the maximum reimbursable levels of compensation payable by insurers to doctors for medical services provided to patients insured under Maricopa Foundation-endorsed plans increased approximately 33.3%.

98. Between 1970 and November, 1974, the Foundation fee schedule for anesthesia increased approximately 31 per cent.

The Maricopa Foundation only admits that its conversion factor applicable to determination of the maximum reimbursable levels of compensation payable by insurers to doctors for anesthesia increased approximately 33% during the period 1970 to November 1974.

99. Between 1970 and November, 1974, the Foundation fee schedule for surgery increased approximately 31 per cent.

The Maricopa Foundation only admits that between 1970 and November 1974 its conversion factor applicable to determine the maximum reimbursable levels of compensation payable by insurers to doctors for surgical services provided to patients insured under Maricopa Foundation-endorsed plans increased approximately 31%.

100. Between 1970 and November, 1974, the Foundation fee schedule for pathology increased approximately 30 per cent.

The Maricopa Foundation only admits that between 1970 and November 1974 its conversion factor applicable to determine the maximum reimbursable levels of compensation payable by insurers to doctors for pathological services provided to patients insured under Maricopa Foundation-endorsed plans increased approximately 31%.

101. *Round-Up* is a regular publication of the Society.

The Maricopa Foundation has no information sufficient to admit or deny the truth or falsity of this statement and refers to the response provided by the Maricopa Society for Medical Care.

102. *Round-Up* is published, circulated or distributed to the Society's members.

The Maricopa Foundation has no information sufficient to admit or deny the truth or falsity of this statement and refers plaintiff to the response provided by the Maricopa Society for Medical Care.

103. In or about January, 1973, the Foundation fee schedule was published in *Round-Up*.

The Maricopa Foundation has no information sufficient to admit or deny the truth or falsity of this statement and refers plaintiff to the response provided by the Maricopa Society for Medical Care.

104. In or about March, 1973, the Foundation's Minimum Standards Committee consulted with the Arizona Society of Internal Medicine on criteria for coverage of annual physical examinations.

Maricopa Foundation only admits that in or about March 1973, Maricopa Foundation's Minimum Standards Committee consulted with the Arizona Society of Internal Medicine on criteria for health insurance coverage of annual physical examinations.

105. In or about March, 1973, the Foundation's Minimum Standards Committee consulted with the Phoenix Psychiatric Council on criteria for coverage of psychological services.

Maricopa Foundation only admits that in or about March 1973, Maricopa Foundation's Minimum Standards Committee consulted with the Phoenix Psychiatric Council on criteria for health insurance coverage of psychological services.

106. In or about March, 1973, the Foundation's Minimum Standards Committee consulted with the Arizona Chapter of the American Academy of Orthopedic Surgeons on criteria for coverage of doctors' services rendered by orthopedic assistants.

Maricopa Foundation only admits that in or about March 1973, Maricopa Foundation's Minimum Standards Committee consulted with the Arizona Chapter of the American Academy of Orthopedic Surgeons on criteria for health insurance coverage of doctors' services rendered by orthopedic assistants.

107. In or about March, 1973, the Foundation's Minimum Standards Committee consulted with the Phoenix Pediatric Society on criteria for coverage of well baby care.

Maricopa Foundation only admits that in or about March 1973, Maricopa Foundation's Minimum Standards Committee consulted with the Phoenix Pediatric Society on criteria for health insurance coverage of well baby care.

108. In or about March 20, 1973, the Foundation's Board of Trustees reviewed the work of the Foundation's Minimum Standards Committee.

The Maricopa Foundation only admits that on or about March 30, 1973 its Board of trustees reviewed the March 6, 1973 minutes of the Maricopa Foundation's Minimum Standards Committee.

109. On or about March 20, 1973, the Foundation's Board of Trustees directed the Chariman of the Foundation's Minimum Standards Committee to obtain the recommendation of the Phoenix OB-GYN Society on coding for obstetrical and gynecological services.

The Maricopa Foundation only admits that on or about March 20, 1973, Dr. Pent, a Maricopa Foundation board member, agreed to follow-up on the Maricopa Foundation's request to the Phoenix OB-GYN Society for its recommendation concerning the coding of cesarian sections for use in health insurance coverage.

110. In or about April, 1973, the Foundation's Minimum Standards Committee sent the report of its sub-committee on well baby care to the Phoenix Pediatric Society.

The Maricopa Foundation only admits that the April 10, 1973 minutes of its Minimum Standards Committee state that a copy of the report of its subcommittee on well baby care would be sent to the Arizona Pediatric Society.

111. In or about April, 1973, the Foundation's Minimum Standards Committee sent the report of its sub-committee on well baby care to the Phoenix Chapter American Academy of Family Practice.

The Maricopa Foundation only admits that the April 10, 1973 minutes of its Minimum Standards Committee state that a copy of the report of its subcommittee on well baby care would be sent to the American Academy of family Practice.

112. In or about April, 1973, the Foundation's Minimum Standards Committee requested the advice of the Phoenix Psychiatric Council on coverage for psychological services.

The Maricopa Foundation only admits that the April 10, 1973 minutes of its Minimum Standards Committee state that the committee should meet with members of the Phoenix Psychiatric Society and members of the local psychological association for their recommendations with respect to inclusion in the minimum standards for health insurance plans of payment for psychological testing.

113. In or about April, 1973, the Foundation's Minimum Standards Committee requested the advice of the an orthopedic society on appropriate coverage of services performed by orthopedic surgeons.

The Maricopa Foundation only admits that the April 10, 1973 minutes of its Minimum Standards Committee state that the Orthopedic Society would be asked to make a recommendation with respect to the utilization of orthopedic services covered under Maricopa Foundation-endorsed health insurance plans.

114. In or about April, 1973, the Foundation's Board of Trustees decided not to establish a fee schedule for obstetrical and gynecological services without the advice of the Phoenix OB-GYN Society.

The Maricopa Foundation only admits that on or about April 1973 its Board of Trustees decided not to alter the use of the 1964 California Relative Value Schedule with respect to determining maximum reimbursement levels for obstetrical services under Foundation-endorsed health insurance plans and that it would make no changes to maximum levels of reimbursement under Maricopa Foundation-endorsed health insurance plans with respect to such services prior to obtaining information from the Phoenix OB-GYN Society.

115. In or about April, 1973, the Foundation's Board of Trustees agreed to increase the Foundation's allowed fees for obstetrical and gynecological services in accordance with the suggestions of the Phoenix OB-GYN Society.

Denied. See pages 2 and 3 of the Minutes of the Maricopa Foundation's Board of Trustees dated April 17, 1973.

116. On or about April 11, 1973, a representative of the Foundation's Minimum Standards Committee informed members of the Phoenix Psychiatric Council of a fee schedule for emergency services.

The Maricopa Foundation has no information sufficient to admit or deny the truth or falsity of this statement.

117. In or about May, 1973, increases in the unit values used by the Foundation for some doctors' services were published in *Round-Up*.

The Maricopa Foundation has no information sufficient to admit or deny the truth or falsity of this statement and refers plaintiff to the response provided by the Maricopa Society for Medical Care.

118. On or about May 16, 1973, representative(s) of the Foundation's Minimum Standards Committee asked the Phoenix Psychiatric council for information on the prices of various psychiatric services.

The Maricopa Foundation has no information sufficient to admit or deny the truth or falsity of this statement.

119. On or about September 18, 1973, the Foundation's Board of Trustees decided to poll Foundation members with respect to possible increases in the Foundation fee schedule.

Maricopa Foundation only admits that on or about September 18, 1973 the Maricopa Foundation's Board of Trustees decided to poll Foundation cooperating and participating members with respect to a proposed increase in Maricopa Foundation's maximum reimbursable payment for medical services rendered to patients insured under Maricopa Foundation-endorsed plans.

120. On or about September 18, 1973, the Foundation's Board of Trustees recommended that Foundation members approve a 7.5 percent increase in the Foundation fee schedule.

Maricopa Foundation only admits that on or about September 18, 1973, the Maricopa Foundation's Board of Trustees recommended that Foundation members approve a 7.5% increase in Maricopa Foundation's maximum reimbursable payment for medical services rendered to patients insured under Maricopa Foundation-endorsed plans.

121. Prior to September 18, 1973, the Internal Revenue Service indicated it would allow a maximum 7.5 percent increase in the Foundation fee schedule.

Maricopa Foundation only admits that prior to September 18, 1973 it was informed by the United States Government that a 7.5% increase in maximum reimbursable payments for medical services rendered to patients insured under Maricopa Foundation-endorsed plans was the maximum allowed under the federal government's wage and price controls then in effect.

122. On or about November 1, 1973, representative(s) of the Foundation's Fee Schedule Committee met with representatives of the Phoenix Surgical Society regarding possible increases in the unit values used by the Foundation for certain surgical services.

Maricopa Foundation only admits that on or about November 1, 1973 representatives of Maricopa Foundation's Fee Schedule Committee met with representatives of the Phoenix Surgical Society concerning possible increases in unit values used by Maricopa Foundation to determine maximum reimbursable payment for medical services rendered to patients insured under Maricopa Foundation-endorsed health insurance plans.

123. On or about November 14, 1973, a representative of the Phoenix OB-GYN Society informed a representative of the Foundation's Fee Schedule Committee of the results of

a fee survey conducted by the Phoenix OB-GYN Society on the fees its members charged for certain obstetrical and gynecological services.

Admit.

124. On or about November 14, 1973, representatives of the Phoenix OB-GYN Society conveyed to representatives of the Foundation's Fee Schedule Committee proposed increases in the fees allowed by the Foundation for certain obstetrical and gynecological services.

Admit only that on or about November 15, 1973 representatives of the Phoenix OB-GYN Society conveyed to representatives of the Foundation's Fee Schedule Committee proposed increases in the maximum reimbursable payment for certain obstetrical and gynecological services rendered to patients insured under Maricopa Foundation-endorsed health insurance plans.

125. On or about November 14, 1973, representatives of the Phoenix OB-GYN Society conveyed to representatives of the Foundation's Fee Schedule Committee the Phoenix OB-GYN Society's support for proposed increases in the fees allowed by the Foundation for certain obstetrical and gynecological services.

Admit only that on or about November 14, 1973 representatives of the Phoenix OB-GYN Society conveyed to representatives of the Foundation's Fee Schedule Committee proposed increases in the maximum reimbursable payment for certain obstetrical and gynecological services rendered to patients insured under Maricopa Foundation-endorsed health insurance plans.

126. On or about November 14, 1973, representative(s) of the Foundation's Fee Schedule Committee met with representatives of any orthopedic society regarding the use of the 1969 edition of the California Relative Value Schedule for certain surgical services.

Admit only that on or about November 14, 1973 representatives of the Maricopa Foundation's Fee Schedule Committee met with representatives of an orthopedic society concerning use of the 1969 edition of the California Relative Value Schedule to determine maximum reimbursable payment for certain surgical services rendered to patients insured under Maricopa Foundation-endorsed health insurance plans.

127. On or about November 20, 1973, the Chairmen of the Foundation's Fee Schedule Committee reported to the Foundation's Board of Trustees on a meeting of said Chairmen with representatives of an orthopedic society.

Admit.

128. On or about November 20, 1973, the Chairmen of the Foundation's Fee Schedule Committee reported to the Foundation's Board of Trustees on a meeting of said Chairmen with representatives of the Arizona Society of Internal Medicine.

Admit.

129. On or about November 20, 1973, the Chairmen of the Foundation's Fee Schedule Committee recommended to the Foundation's Board of Trustees certain changes in the unit values used by the Foundation for certain surgical, obstetrical and gynecological procedures.

Admit only that on or about November 20, 1973 the Chairman of the Maricopa Foundation's Fee Schedule Committee recommended to the Foundation's Board of Trustees various changes in unit values used by the Maricopa Foundation to determine maximum reimbursable payment for certain surgical, obstetrical and gynecological services rendered to patients insured under Maricopa Foundation-endorsed health insurance plans.

130. On or about November 20, 1973, the Chairmen of the Foundation's Fee Schedule Committee recommended to the Foundation's Board of Trustees that the Foundation poll various groups of doctors with respect to the Foundation fee schedule.

Admit only that on or about November 20, 1973 the Chairman of the Maricopa Foundation's Fee Schedule Committee recommended to the Foundation's Board of Trustees that the Maricopa Foundation survey various professional organizations with respect to the maximum reimbursable payment for medical services rendered to patients insured under Maricopa Foundation-endorsed health insurance plans.

131. On or about November 20, 1973, the Chairmen of the Foundation's Fee Schedule Committee informed the Foundation's Board of Trustees that they planned to continue meeting with groups of doctors concerning the unit values which the Foundation used for or accorded to the services in which those respective groups of doctors specialized.

Denied. See Minutes of the Maricopa Foundation Board of Trustees dated November 20, 1973.

132. Prior to December, 1973, the Phoenix Pediatric Society requested the revision of the Foundation's minimum standards to require coverage of well baby care.

The Maricopa Foundation only admits that sometime after April 10, 1973 its subcommittee on well baby care submitted its report with respect to the inclusion of well-baby coverage in the Maricopa Foundation's minimum standards to the Arizona Pediatric Society for its comments, that on or about December 18, 1973 the Maricopa Foundation's Minimum Standards Committee recommended and its Board of Trustees approved the inclusion of well baby care in the Maricopa Foundation's minimum

standards, that on or about January 15, 1974 the Maricopa Foundation's Board of Trustees reversed its decision and well baby care has at all times not been required by the Maricopa Foundation's minimum standards.

133. On or about December 18, 1973, the Foundation's Board of Trustees approved revision of the Foundation's minimum standards to require coverage of doctors' services for well baby care under Foundation Plans.

Maricopa Foundation repeats its response to statement 132.

134. Prior to December 18, 1973, an orthopedic society recommended to the Foundation that the services of orthopedic assistants who were not doctors should not be covered under Foundation Plans.

The Maricopa Foundation only admits that the American Academy of Orthopedic Surgeons and the Central Orthopedic Association of Arizona provided information to the Foundation's Minimum Standards Committee used by it in making its recommendations that charges for the services of orthopedic assistants who were not doctors should not be required to be reimbursed under Foundation-endorsed medical health insurance plans.

135. On or about December 18, 1973, the Foundation's Board of Trustees decided not to revise the Foundation's minimum standards to require coverage of the services of orthopedic assistants who were not doctors.

The Maricopa Foundation only admits that on or about December 18, 1973 its Board of Trustees decided not to revise the Foundation's minimum standards to require that services of orthopedic assistants who were not doctors should be required to be reimbursed under Foundation-endorsed medical health insurance plans.

136. On or about January 1, 1974, the Foundation increased the unit values and the conversion factors used by the Foundation for certain obstetrical and gynecological services.

The Maricopa Foundation only admits that on or about December 18, 1973 its Board of Trustees approved increases in unit values for certain obstetrical and gynecological procedures to be effective January 1, 1974 and that increases in conversion factors effective January 1, 1974 were applicable to those procedures and that those unit values and conversion factors were for use in determining maximum reimbursable payment for those procedures performed on patients insured under Maricopa Foundation-endorsed health insurance plans.

137. The Phoenix OB-GYN Society had recommended the increases adopted by the Foundation in January, 1974 in the unit values and conversion factors used by the Foundation for certain obstetrical and gynecological services.

Maricopa Foundation only admits that the recommendations of the Phoenix OB-GYN Society to Maricopa Foundation for increases in unit values and conversion factors used by the Foundation to determine maximum reimbursable payment for certain obstetrical and gynecological services performed for patients insured under Maricopa Foundation-endorsed health insurance plans were the same as the increases approved by the Foundation.

138. On or about January 1, 1974, one risk modifier for anesthesia was added to the Foundation fee schedule.

Maricopa Foundation admits only that on or about January 1, 1974 one risk modifier for anesthesia was added in determining the maximum reimbursable payment for anesthesiological services performed for patients insured under Maricopa Foundation-endorsed health insurance plans.

139. On or about January 1, 1974, the Foundation increased the unit values used by the Foundation for various surgical services.

Maricopa Foundation only admits that on or about January 1, 1974 the Foundation increased the unit values used by it to determine the maximum reimbursable payment for certain surgical services performed on patients insured under Maricopa Foundation-endorsed health insurance plans.

140. On or about January 1, 1974, the Foundation increased the conversion factor used by the Foundation for surgery.

Maricopa Foundation only admits that on or about January 1, 1974 the conversion factor used by it to determine the maximum reimbursable payment for surgical services performed on patients insured under Maricopa Foundation-endorsed health insurance plans effective on or after January 1, 1974 was increased.

141. On or about January 1, 1974, the Foundation's fee schedule was increased by approximately 7.5 percent.

Maricopa Foundation only admits that the conversion factors adopted by it for use to determine maximum reimbursable payment for medical services performed on patients insured under Maricopa Foundation-endorsed health insurance plans were increased approximately 7.5% with respect to such plans effective on or after January 1, 1974.

142. In January 1974, the Motorola Corporation conveyed to the Foundation statistics showing that doctors' fees incurred by Motorola employees in the Phoenix area were significantly higher than doctors' fees incurred by Motorola employees in the Chicago area.

The Maricopa Foundation only admits that on or about February 28, 1973 Motorola, Inc. transmitted statistics comparing health care costs in Phoenix and Chicago during 1971-72 which statistics were briefly discussed during the Board of Trustees meeting of the Maricopa Foundation on or about January 15, 1974.

143. On or about November 30, 1973, the Foundation asked an insurance consultant to estimate the increases in premiums on Foundation Plans that would be caused by the increases in the Foundation fee schedule effective January 1, 1974.

Maricopa Foundation only admits that on or about November 30, 1973 the Foundation asked an insurance consultant to provide actuarial assistance in estimating increases in premiums on Foundation-endorsed health insurance plans likely to occur as a result of increases in the maximum reimbursable payment for medical services performed on patients insured under Maricopa Foundation-endorsed health insurance plans proposed to become effective with respect to such plans on or after January 1, 1974.

144. In or about January, 1974, Cal Western realized an incurred loss in excess of $47,000 on the Maricopa Society's group insurance trust for 1973.

Maricopa Foundation only admits that for the twelve month period ending January 31, 1974, Cal Western Life estimated an incurred loss with respect to the Maricopa County Medical Society Group Insurance Trust of $47,166.00.

145. By January, 1974, Cal Western's incurred loss on the Maricopa Society group insurance trust totalled over $79,000.

Admitted.

146. On or about January 8, 1974, the Society's Board of Directors approved a 10 percent increase in premiums on the Society's own group insurance trust.

The Maricopa Foundation has no information sufficient to admit or deny the truth or falsity of this statement and refers plaintiff to the response provided by the Maricopa Society for Medical Care.

147. The 10 percent premium increase approved in January, 1974 on the Society's group insurance trust was necessary to cover increases in the Foundations fee schedule and the additional coverage of obstetrical and well baby care.

The Maricopa Foundation has no information sufficient to admit or deny the truth or falsity of this statement and refers plaintiff to the response provided by the Maricopa Society for Medical Care.

148. In or about January, 1974, the Foundation formed an Insurance Advisory Committee.

Admitted.

149. After Federal Wage and Price Controls were lifted in 1974, the Foundation took steps to increase the Foundation fee schedule to a level approximating the usual or customary fees for doctors' services in Maricopa County.

Denied.

150. On or about June 11, 1974, the Foundation sent a uniform health insurance claim form endorsed by the Arizona Medical Association to doctors in Maricopa County, Arizona.

Admitted.

151. On or about June 14, 1974, the Foundation's Executive Director made a written report to the Foundation's Executive Committee on the operations and philosophy of the Foundation.

Admit only that on or about June 14, 1974, the Maricopa Foundation's Executive Director made a written report to the Foundation's Executive Committee and refer to that report for its contents.

152. On or about June 17, 1974, the Foundation's Board of Trustees decided to prepare a new Foundation fee schedule which would increase the fees allowed for doctors' services to Foundation policyholders.

The Maricopa Foundation only admits that on or about June 17, 1974, its Board of Trustees discussed the possibility of increasing the conversion factors then in effect with respect to determining maximum reimbursable levels for medical services provided to patients insured under Maricopa Foundation-endorsed health insurance plans.

153. On or about June 14, 1974, the Foundation's Board of Trustees decided to poll Foundation members on the relative value schedules and conversion factors they were using.

The Maricopa Foundation only admits that on or about June 17, 1974, its Board of Trustees decided to survey the Maricopa Foundation membership with respect to the fees charged by them, as expressed by a relative value schedule and conversion factor in order to obtain an overall view of the current trends in medical charges in the community.

154. Beginning on or about June 20, 1974, the Foundation polled Foundation members to determine the fees they were charging for their services.

Admit.

155. On or about June 27, 1974, the Foundation informed the members of the Foundation's Insurance Advisory Committee of the Foundation's expectation that the Foundation fee schedule would be increased.

The Maricopa Foundation only admits that on or about June 27, 1974 the Insurance Advisory Committee discussed a possible increase in the conversion factors used by Maricopa Foundation to determine maximum reimbursable levels for medical services provided to patients insured under Maricopa Foundation-endorsed health insurance plans.

156. On or about July 5, 1974, the Foundation sent Foundation members a ballot for approval of an increased Foundation fee schedule.

The Maricopa Foundation only admits that on or about July 5, 1974 the Maricopa Foundation sent its members ballots through which they could approve or disapprove proposed conversion factors to be used in connection with determining the maximum level of reimbursement payable to physicians for services rendered to patients insured under Maricopa Foundation-endorsed health insurance plans.

157. On or about July 5, 1974, the Foundation informed its members that the Foundation was seeking to make its fee schedule consistent with the usual and customary fee for doctors' services in the community.

Admit only that on or about July 5, 1974 the Maricopa Foundation wrote to its members that one of its goals was to make the maximum reimbursable levels for medical services provided to patients insured under Maricopa Foundation-endorsed health insurance plans consistent with usual and customary fees for doctors services in the community.

158. By July 15, 1974, Foundation members had approved the proposed increases in the Foundation fee schedule by a vote of approximately 291 to 19.

Admit only that by July 15, 1974 Maricopa Foundation members had voted to approve an increase in maximum reimbursable levels for medical services provided to patients insured under Maricopa Foundation-endorsed health insurance plans by a margin of approximately 291 to 19.

159. On or about July 15, 1974, the Foundation's Board of Trustees discussed the Foundation's use of the relative value schedule prepared by the American College of Radiology in lieu of the 1964 California Relative Value Schedule for Radiology.

The Maricopa Foundation only admits that on or about July 15, 1974 its Board of Trustees discussed the possibility of incorporating in lieu of the 1964 California Relative Value Schedule the relative value schedule prepared by the American College of Radiology into its minimum standards with respect to maximum reimbursable levels for radiological procedures provided by physicians to patients insured under Maricopa Foundation-endorsed health insurance plans.

160. On or about July 15, 1974, the Foundation's Board of Trustees considered establishing a conversion factor of 7 for radiology, but decided to poll the radiologists in the community to see if that was sufficient.

The Maricopa Foundation only admits that on or about July 15, 1974 its Board of Trustees considered using a conversion factor of 7.0 in conjunction with the American College of Radiology relative value schedule to determine maximum reimbursable levels for radiological procedures, but decided to survey local radiologists to determine whether that conversion factor would result in maximum reimbursement levels for radiological services supplied to patients insured under Maricopa Foundation-endorsed health insurance plans comparable to fees currently charged in the community.

161. On or about July 15, 1974, representatives of the Arizona Psychiatric Society complained to the Foundation's Board of Trustees that the coverage of psychiatric services required by the Foundation's minimum standards was inadequate.

The Maricopa Foundation only admits that on or about July 15, 1974 its Board of Trustees received a complaint from the president of the Arizona Psychiatric Society that the Maricopa Foundation maximum reimbursable level of $10.00 per visit for patients insured under Maricopa Foundation-endorsed health insurance plans was unsatisfactory.

162. On or about July 15, 1974, Patrick Moraca reported to the Foundation's Board of Trustees on his meeting with representatives of the Arizona Chapter of the American Academy of Family Practice.

Admit.

163. On or about July 29, 1974, the Foundation informed insurers that were underwriting Foundation Plans of the increased Foundation fee schedule and revised Foundation minimum standares to be effective November 1, 1974.

Admit only that on or about July 29, 1974 the Maricopa Foundation informed insurers that were underwriting Maricopa Foundation-endorsed health insurance plans that effective November 1, 1974 the Maricopa Foundation's revised minimum standards would take effect and maximum reimbursable levels for medical services for patients insured under Maricopa Foundation-endorsed health insurance plans would increase.

164. By August 19, 1974, the Foundation members approved the recommended increases in the Foundation fee schedule by a vote of approximately 657 to 53.

Admit only that on or about August 19, 1974 the Maricopa Foundation members had voted to approve an increase in maximum reimbursable levels for medical services provided to patients insured under Maricopa Foundation-endorsed health insurance plans by a margin of approximately 657 to 53.

165. On or about August 19, 1974, the Foundation's Board of Trustees appointed a committee to study possible coverage of the services of surgical assistants who were not doctors.

Admit only that on or about August 19, 1974, the Maricopa Foundation's Board of Trustees appointed a committee to study possible medical insurance coverage of the services of surgical assistants who were not doctors under Maricopa Foundation-endorsed health insurance plans.

166. On or about August 19, 1974, the Foundation's Board of Trustees directed the Chairman of the Foundation's committee to study possible coverage of the services of non-doctor surgical assistants to obtain the opinion of the Phoenix Surgical Society on such coverage.

The Maricopa Foundation admits only that on or about August 19, 1974 its Board of Trustees decided to send a letter to the Phoenix Surgical Society asking that group's opinion and recommendation with respect to health insurance coverage under Maricopa Foundation-endorsed health insurance plans of services provided by surgical assistants.

167. On September 10, 1974, the Foundation asked the opinion of the Phoenix Surgical Society on coverage for services provided by surgical assistants who were not doctors.

The Maricopa Foundation admits only that on or about September 10, 1974, it asked the Phoenix Surgical Society to review the concept of the use of surgical assistants in order for the Maricopa Foundation to determine whether

coverage under Maricopa Foundation-endorsed health insurance plans of use of assistants would reduce the cost of medical care while at the same time provide quality and necessary medical care.

168. On or about October 11, 1974, the Foundation published, circulated or distributed a report on its five-year history which showed 30 per cent to 33.3 percent increases in the Foundation fee schedule between 1970 and November 1, 1974.

Admit only that on or about October 11, 1974, the Maricopa Foundation published, circulated or distributed a report on its five-year history and that report showed 30 to 33.3% increases in maximum levels of compensation payable by insurers to doctors for services provided to patients insured under Maricopa Foundation-endorsed health insurance plans between 1970 and November 1, 1974.

169. On or about October 11, 1974, the Foundation sent Foundation members a report showing 30 percent to 33.3 percent increases in the Foundation fee schedule between 1970 and November 1, 1974.

Admit only that on or about October 11, 1974, the Maricopa Foundation published, circulated or distributed a report on its five-year history and that report showed 30 to 33.3% increases in maximum levels of reimbursement payable by insurers to doctors for services provided to patients insured under Maricopa Foundation-endorsed health insurance plans between 1970 and November 1, 1974.

170. On or about October 16, 1974, the Executive Director of the Foundation sent the Foundation's minimum standards on well baby care to a representative of the Pima Foundation.

Admitted.

171. On or about October 16, 1974, the Foundation's Executive Director sent the Foundation fee schedule effective November 1, 1974 to a representative of the Pima Foundation.

The Maricopa Foundation only admits that on or about October 16, 1974 the Foundation's Executive Director sent the conversion factors used by it to determine maximum levels of reimbursement payable by insurers to doctors for services provided to patients insured under Maricopa Foundation-endorsed health insurance plans to a representative of the Pima Foundation.

172. In or about November, 1974, an article which reported a 33 percent increase in Foundation fee schedules since 1970 was published in *Round-Up*.

The Maricopa Foundation has no information sufficient to admit or deny the truth or falsity of this statement and refers plaintiff to the response provided by the Maricopa Society.

173. In or about November, 1974, the Foundation fee schedule effective November 1, 1974 was published in *Round-Up*.

The Maricopa Foundation has no information sufficient to admit or deny the truth or falsity of this statement and refers plaintiff to the response provided by the Maricopa Society.

174. In or about November, 1974, the Foundation fee schedule effective November 1, 1974 was provided to the Occupational Health Committee of the Arizona Medical Association.

The Maricopa Foundation has no information sufficient to admit or deny the truth or falsity of this statement and refers plaintiff to the response provided by the Maricopa Society.

175. In or about November or December, 1974, the Foundation told Dr. Glenn Friedman that his proposal for a pediatric early discharge program to curb medical costs should be presented to the pediatric society before being presented for approval to the Foundation's Board of Trustees.

The Maricopa Foundation only admits that on or about December 20, 1974, its president asked Dr. Glenn Friedman to discuss his suggested programs for early hospital discharge for new borns and other pediatric patients to curb medical costs with the Pediatric Society.

176. On or about November 12, 1974, the Foundation sent its five-year report showing 30 to 33.3 percent increases in Foundation fee schedules between 1970 and November 1, 1974 to non-member doctors with applications for membership in the Foundation.

Admit only that on or about November 12, 1974 the Maricopa Foundation sent a report on its five-year history to non-member doctors with applications for membership in the Maricopa Foundation and that report showed 30 to 33.3% increases in maximum levels of reimbursement payable by insurers to doctors for services provided to patients insured under Maricopa Foundation-endorsed health insurance plans between 1970 and November 1, 1974.

177. On or about December 10, 1974, the Society's Board of Directors elected six new trustees to the Foundation's Board of Trustees.

The Maricopa Foundation only admits that in December 1974 the administrative members of the Maricopa Foundation re-elected two persons to the Board of Trustees and elected five additional persons to the Foundation's Board of Trustees.

178. On or about December 12, 1974, the Foundation held meetings for doctors in Scottsdale, Mesa, Tempe and Chandler at which members of the Foundation's Board of Trustees discussed Foundation activities with those who attended.

Admit.

179. On or about December 16, 1974, representatives of the Phoenix Psychiatric Council presented to the Foundation's Board of Trustees the Council's recommendation for required coverage for outpatient psychiatric care under Foundation Plans.

The Maricopa Foundation only admits that on or about December 16, 1974 representatives of the Psychiatric Council presented recommendations to the Maricopa Foundation's Board of Trustees for inclusion of outpatient psychiatric coverage in the Maricopa Foundation's minimum standards for endorsed health insurance plans.

180. On or about December 16, 1974, the Foundation's Board of Trustees asked representatives of the Phoenix Psychiatric Council to help the Foundation prepare criteria for coverage of outpatient psychiatric care under Foundation Plans.

The Maricopa Foundation only admits that on or about December 16, 1974 its Board of Trustees decided to ask the Psychiatric Council for assistance in formulating peer review guidelines for both inpatient and outpatient review of claims under Maricopa Foundation-endorsed health insurance plans.

181. On or about January 23, 1975, the Foundation asked the Phoenix OB-GYN Society to decide whether a surgical assistant was necessary for certain obstetrical and gynecological procedures.

The Maricopa Foundation only admits that on or about January 23, 1975, it asked the Phoenix OB-GYN Society for its opinion whether a surgical assistant is medically necessary for the performance of vaginal tubal ligations for the

purpose of determining whether Maricopa Foundation-endorsed health insurance plans should provide reimbursement for such services.

182. In or about January, 1975, Foundation representative(s) met with representatives of the Phoenix Psychiatric Council.

The Maricopa Foundation only admits that in December 1974 representatives of the Phoenix Psychiatric Council met with the Maricopa Foundation's Board of Trustees. *See* letter of Patrick P. Moraca to Howard Gray, M.D. dated January 16, 1975.

183. In or about January, 1975, the Foundation agreed to endorse coverage of up to $800 for outpatient psychiatric care under Foundation Plans.

The Maricopa Foundation only admits that commencing November 1, 1974 it included within its minimum standards for Foundation-endorsed health insurance plans coverage for outpatient psychiatric services at the rate of 50% of the first $20.00 of insured charges per treatment with a maximum benefit of $750.00 per year.

184. In or about January, 1975, the Foundation decided not to include coverage of the cardiac conditioning program of the Arizona Heart Institute in its minimum standards for Foundation Plans.

Admit.

185. In or about January, 1975, the Foundation informed Greyhound Corporation of the Foundation's decision not to include coverage of the cardiac conditioning program of the Arizona Heart Institute in its minimum standards or Foundation Plans.

The Maricopa Foundation only admits that on or about January 24, 1975 it informed the Greyhound Corporation that its Board of Trustees had decided not to include the

cardiac conditioning program of Cardiovascular Diagnostic Laboratories Inc. within the minimum standards of the Maricopa Foundation for Maricopa Foundation-endorsed health insurance plans.

186. In or about January, 1975, the Foundation provided the Foundation fee schedule for 1975 to the Pima Foundation.

Admit only that on or about October 16, 1974 the Maricopa Foundation's Executive Director sent the conversion factors used by it to determine maximum levels of compensation payable by insurers to doctors for services provided to patients insured under Maricopa Foundation-endorsed health insurance plans to a representative of the Pima Foundation.

187. On or about February 1, 1975, Pacific Mutual Life Insurance Company replaced Cal Western as the underwriter for the society's group insurance trust.

Admit.

188. On or about February 1, 1975, Pacific Mutual Life Insurance Company increased the premium on the Society's group insurance trust by approximately 26 per cent over the 1974 premium.

Admit.

189. At a meeting of the Medical Economics Committee of the Arizona Medical Association on or about March 1, 1975, the Foundation's President discussed the Foundation's preparation of a relative value schedule for Arizona doctors.

The Maricopa Foundation is without information sufficient to admit or deny the truth or falsity of this statement.

190. On or about March 1, 1975, the Foundation's President told members of the Medical Economics Committee of the Arizona Medical Association that the relative value

schedule which the Foundation was preparing would incorporate features of the 1969 and 1974 editions of the California Relative Value Schedule and use a consistent point system in all sections.

The Maricopa Foundation is without information sufficient to admit or deny the truth or falsity of this statement.

191. On or about May 12, 1975, the Foundation's Executive Director conveyed to the Foundation's Fee Schedule Committee a doctor's comments on the Foundation's fee schedule for thoracic surgery.

The Maricopa Foundation only admits that on or about March 12, 1975 its Executive Director informed a physician that his letter dated March 6, 1975 with respect to maximum reimburseable allowances for services to patients insured under Maricopa Foundation-health insurance plans for certain procedures performed by thoracic surgeons had been referred to the Maricopa Foundation's fee schedule committee.

192. On or about May 12, 1975, the Foundation's Executive Director requested a report from the Foundation's Fee Schedule Committee on the comments of the "thoracic community" with respect to the Foundation's allowed fees for thoracic surgery.

The Maricopa Foundation only admits that on or about May 5, 1975, its President requested the Maricopa Foundation's fee schedule committee to pursue an adjustment to the California Relative Value Schedule with respect to tube thorastomy, if justified, and to investigate other possible discrepancies with respect to the Maricopa Foundation's maximum level of reimbursement for medical care of patients insured under Maricopa Foundation-endorsed health insurance plans for other surgical procedures.

193. On or about May 20, 1975, the Chairman of the Foundation's Fee Schedule Committee asked the presidents of various groups of doctors to designate representatives to meet with the Committee in order to propose changes, additions or deletions in the unit values used by the Foundation.

The Maricopa Foundation only admits that on or about May 20, 1975, the Chairman of the Maricopa Foundation Fee Schedule Committee asked the presidents of physician specialty societies to submit names of two or three of their member physicians who would be willing to meet with the Committee to propose any changes, additions or deletions to the Maricopa Foundation's conversion factors used to establish maximum reimbursable allowances for services to patients insured under Maricopa Foundation-endorsed health insurance plans that would reflect the practice patterns of each specialty.

194. On or about May 20, 1975, three members of the Foundation's Board of Trustees held a meeting with the Foundation's Fee Schedule Committee at which the collection of data on doctors' fees in connection with the preparation of the Foundation fee schedule for 1976 was discussed.

The Maricopa Foundation only admits that two members of its Board of Trustees and its Executive Director met with its Fee Schedule Committee on or about May 20, 1975 and they discussed the possibility of increasing conversion factors used to determine maximum levels of reimbursement for medical care of patients insured under Maricopa Foundation-endorsed health insurance plans.

195. On or about May 30, 1975, the Foundation's Executive Director met with the Foundation's Fee Schedule Committee concerning the possibility of increasing the Foundation fee schedule.

See the response to statement 194 herein.

196. On or about May 30, 1975, the Foundation's Executive Director met with the Foundation's Fee Schedule Committee concerning the Committee's progress in developing a relative value schedule for Arizona doctors.

The Maricopa Foundation only admits that two members of its Board of Trustees and its Executive Director met with its Fee Schedule Committee on or about May 20, 1975 and they discussed the progress of Dr. Moraca in developing a relative value schedule for use in Arizona.

197. In or about June, 1975, *Round-Up* published summaries of determinations of the society's Grievance Committee which approved doctors' fees billed in accordance with the relative value schedules used by the Foundation.

The Maricopa Foundation has no information sufficient to admit or deny the truth or falsity of this statement and refers plaintiff to the response provided by the Maricopa County Medical Society.

198. On or about April 8, 1975, the Foundation's Board of Trustees appointed a delegate to report to the Society's Board of Directors on the activities of the Foundation.

The Maricopa Foundation only admits that on or about March 18, 1975, its Board of Trustees appointed one of its members to inform the Board of Directors of the Maricopa County Medical Society of the Maricopa Foundation's activities.

199. Beginning on or about April 8, 1975, minutes of meetings of the Foundation's Board of Trustees were sent to members of the Society's Board of Directors.

The Maricopa Foundation only admits that for a period beginning on or about April 8, 1975 and continuing thereafter for two or three months, the Maricopa Foundation transmitted copies of the minutes of its Board of trustees to the Board of Directors of the Maricopa County Medical Society.

200. On or about May 13, 1975, a representative of the Foundation read the minutes of a previous meeting of the Foundation's Board of trustees at a meeting of the Society's Board of Directors.

Admit.

201. On or about June 10, 1975, a representative of the Foundation reported to the Society's Board of Directors on the activities of the Foundation.

Admit.

202. The Foundation's functions were discussed at a joint meeting of the Foundation's Board of Trustees and the Society's Board of Directors on or about July 8, 1975.

Admit.

203. Members of the Society's Board of Directors toured the Foundation's facilities on or about July 8, 1975.

Admit.

204. In or about August, 1971, representatives of the Foundation attended a meeting of the American Association of Foundations for Medical Care in Vail, Colorado.

The Maricopa Foundation only admits that its representatives attended a meeting of the American Association of Foundations for Medical Care held in Vail, Colorado in August 1973.

205. In or about August, 1971, a representative of the Foundation was elected Vice President of a regional Association of Foundations for Medical Care.

Admit only that in or about August 1971 a representative of the Maricopa Foundation was elected Vice President of the American Association of Foundations for Medical Care.

206. In or about June or July 1973, a representative of the Foundation attended a regional meeting of the American Association of Foundations for Medical Care at Mackinac Island, Michigan.

Admit.

207. On or about July 17, 1973, the Foundation's Board of Trustees heard a report concerning a regional meeting of the American Association of Foundations for Medical Care at Mackinac Island, Michigan from a Foundation representative who attended that meeting.

Admit.

208. In or about November, 1973, the Foundation's Executive Director attended a meeting of the American Association of Foundations for Medical Care in San Diego, California.

Admit.

209. In or about January or February of 1974, a representative of the Foundation attended a Board meeting of the American Association of Foundations for Medical Care.

Admit.

210. On or about February 26, 1974, the Foundation's Board of Trustees heard a report concerning a Board meeting of the American Association of Foundations for Medical Care from a Foundation representative who attended that meeting.

Admit.

211. On or about February 26, 1974, materials obtained from the American Association of Foundations for Medical Care were distributed to the Foundation's Board of Trustees.

Admit.

212. From approximately September 29, 1974 through October 2, 1974, the Foundation's President attended a meeting of the American Association of Foundations for Medical Care in Washington, D.C.

The Maricopa Foundation only admits that from approximately September 29, 1974 through October 2, 1974 its Vice President attended a meeting of the American Association of Foundations for Medical Care in Washington, D. C.

213. A representative of the Foundation was a member of the Health Insurance Committee of the American Association of Foundations for Medical Care in 1975.

Admit.

214. A representative of the Foundation was a member of the Insurance Industry Liaison Committee of the American Association of Foundations for Medical Care in 1975.

Admit.

215. In or about August, 1975, a representative of the Foundation attended a meeting of the American Association of Foundations for Medical Care in San Francisco, California.

Admit.

216. In or about August, 1975 a representative of the Foundation chaired a meeting of the Insurance Industry Liaison Committee of the American Association of Foundations for Medical Care in San Francisco, California.

Admit.

217. At a meeting of the American Association of Foundations for Medical Care in San Francisco, California in or about August 1975, a representative of the Foundation obtained materials prepared by California medical societies regarding increases in doctor's fees and the impact of such increases on premiums for Foundation Plans.

The Maricopa Foundation only admits that a representative of the Maricopa Foundation who attended a meeting of the American Association of Foundations for Medical Care in San Francisco, California in August 1975 received copies of material distributed by California Medical Societies which reflected increases in physicians' fees in California that had been necessitated by increased malpractice insurance premiums.

218. On or about August 18, 1975, the Foundation's Board of Trustees heard a report concerning a meeting of the American Association of Foundations for Medical Care in San Francisco, California in August, 1975 from a Foundation representative who attended that meeting.

Admit.

219. On or about August 18, 1975, materials from California medical societies regarding increases in doctors fees and the impact of such increases on premiums for Foundation Plans were distributed to the Foundation's Board of Trustees.

Denied. See Minutes of the Board of Trustees of the Maricopa Foundation dated August 18, 1975.

220. On or about August 18, 1975, the Foundation's Board of Trustees directed that a meeting of the Foundation's Insurance Advisory Committee be scheduled to consider, among other things, increases in the Foundation fee schedule.

The Maricopa Foundation only admits that on or about August 18, 1975, the Maricopa Foundation's Board of Trustees directed that a meeting of the Foundation's Insurance Advisory Committee be scheduled to consider, among other things, changes in the Foundation maximum reimbursable level of compensation payable by the insurer to

doctors for services provided to patients insured under Maricopa Foundation-endorsed medical health insurance plans. *See* Minutes of the Board of Trustees of the Maricopa Foundation dated August 18, 1975.

221. On or about August 19, 1975, materials prepared by foundations for medical care in the State of California concerning increases in doctor's fees were sent to members of the Foundation's Board of Trustees by Foundation employees.

Admit.

222. On or about September 9, 1975, a representative of the Foundation discussed the Foundation's activities at a joint meeting of the Boards of Directors of the Society and the Bureau of Medical Economics.

Admit.

223. On or about September 9, 1975, the Foundation's Insurance Advisory Committee discussed possible increases in the Foundation fee schedule for 1976.

Admit only that on or about September 9, 1975, the Foundation's Insurance Advisory Committee discussed possible increase in the maximum reimbursable level of compensation payable by the insurer to doctors for services provided to patients insured under Maricopa Foundation-endorsed health insurance plans in 1976.

224. On or about September 15, 1975, the Foundation's Board of Trustees discussed the possibility of increasing deductibles on Foundation Plans to offset the increase in premiums that would otherwise be caused by the expected increases in the Foundation fee schedule for 1976.

Admit only that on or about September 15, 1975, the Foundation's Board of Trustees discussed the possibility of increasing deductibles on Maricopa Foundation-endorsed plans to offset the increase in premiums that would otherwise be caused by the expected increase in the maximum reimbursable level of compensation payable by the insurer

to the doctors for services provided to patients insured under Maricopa Foundation-endorsed health insurance plans in 1976.

225. In or about October, 1975, the Foundation conducted a survey among its members to determine their usual fees for doctors' services.

Admit.

226. On or about October 20, 1975, the Foundation's Board of Trustees reviewed the results of the Foundation's fee survey of its membership.

Admit.

227. On or about October 20, 1975, the Foundation's Board of Trustees reviewed the results of a fee survey conducted by the Arizona Medical Association in the fall of 1975.

Admit.

228. On or about October 20, 1975, the Foundation's Board of Trustees approved for submission to Foundation members a proposed Foundation fee schedule for 1976.

Admit only that on or about October 20, 1975, the Foundation's Board of Trustees approved for vote by the participating and cooperating members of the Foundation proposed changes to maximum reimbursable levels of compensation to doctors providing medical services to patients insured under Maricopa Foundation-endorsed health insurance plans for 1976.

229. The Foundation fee schedule effective in 1975 included unit conversion factors of:

(a) 10.00 for medicine;
(b) 8.50 for surgery;
(c) 6.50 for laboratory;
(d) 7.50 for radiology with a professional component of $1.70;
(e) 10.00 for anesthesiology.

Maricopa Foundation only admits that the conversion factors used by Maricopa Foundation to calculate maximum reimbursable levels of compensation payable by the insurer to doctors for services provided to patients insured under Maricopa Foundation-endorsed health insurance plans which became effective in 1975 are as stated in statement 229.

230. The results of the Arizona Medical Association's 1975 fee survey which the Foundation's Board of Trustees reviewed indicated that the average unit conversion factor of respondents was:

(a) 10.21 for medicine;
(b) 9.28 for surgery;
(c) 7.51 for laboratory;
(d) 8.10 for radiology with a professional component of $1.73;
(e) 12.28 for anesthesiology.

The Maricopa Foundation only admits that the Minutes of its Board of Trustees reflects that the Arizona Medical Association's 1975 fee survey indicated that the average conversion factor representative of fees charged by physicians within the State of Arizona for medicine was $10.20; for surgery was $9.28 and for anesthesia was $12.30.

231. The results of the Arizona Medical Association's 1975 fee survey which the Foundation's Board of Trustees reviewed indicated that the median unit conversion factor of respondents was:

(a) 10 for medicine;
(b) 9 for surgery;
(c) 7 for laboratory;
(d) 7.50 for radiology with a professional component of $1.65;
(e) 12 for anesthesiology.

See response to statement 230 herein.

232. The results of the Arizona Medical Association's 1975 fee survey which the Foundation's Board of Trustees reviewed indicated that the mode or most frequent unit conversion factor of respondents was:

(a) 10 for medicine;
(b) 8.50 for surgery;
(c) 6.50 for laboratory;
(d) 7.50 for radiology with a professional component of $1.65;
(e) 12.00 for anesthesiology.

See response to statement 230 herein.

233. The proposed Foundation fee schedule for 1976 included unit conversion factors of:

(a) 11 for medicine:
(b) 9.50 for surgery;
(c) 7 for laboratory;
(d) 8 for radiology with a professional component of $1.85;
(e) 12 for anesthesiology.

Maricopa Foundation only admits that the conversion factors used by Maricopa Foundation to calculate maximum reimbursable levels of compensation payable by the insurer to doctors for services provided to patients insured under Maricopa Foundation-endorsed health insurance plans which became effective in 1976 are as stated in statement 233.

234. The proposed Foundation fee schedule for 1976 was adopted by the Foundation effective January 1, 1976.

Admit only that effective January 1, 1976 maximum reimbursable levels of compensation to doctors providing medical services to patients insured under Maricopa Foundation-endorsed health insurance plans were changed in accordance with the conversion factors referred to in statement 233.

235. On or about October 27, 1975, the Foundation sent ballots for approval of the proposed Foundation fee schedule for 1976 to Foundation members.

The Maricopa Foundation only admits that on or about October 27, 1975, the Maricopa Foundation sent ballots to its members for the approval or disapproval of conversion factors proposed for use in 1976 in determining the maximum level of reimbursement payable to physicians for services rendered to patients insured under Maricopa Foundation-endorsed plans.

236. On or about October 31, 1975, the Foundation informed Blue Cross and Blue Shield of Arizona of increases in the Foundation fee schedule to be effective January 1, 1976.

Admit only that on or about October 31, 1975 the Maricopa Foundation informed Blue Cross and Blue Shield of Arizona of increases in the maximum level of reimbursement payable to physicians for services rendered to patients insured under Maricopa Foundation-endorsed plans to be effective January 1, 1976.

237. At a meeting of the Foundation's Board of Trustees on or about November 17, 1975, representatives of the Phoenix Psychiatric Council requested that the Foundation's minimum standards be revised to provide for coverage of additional outpatient psychiatric services.

Admit only that at a meeting of Maricopa Foundation's Board of Trustees on or about November 17, 1975, representatives of the Phoenix Psychiatric Council requested that Maricopa Foundation's minimum standards for endorsed health insurance plans be revised to provide for coverage of additional outpatient psychiatric services.

238. On or about November 17, 1975, the Foundation's Board of Trustees approved the revisions requested by the Phoenix Psychiatric Council in the Foundation's minimum standards to provide for coverage of outpatient psychiatric services.

Admit only that on or about November 17, 1975 Maricopa Foundation's Board of Trustees approved the revisions requested th the Phoenix Psychiatric Council in the Maricopa Foundation's minimum standards for endorsed health insurance plans to provide for coverage of outpatient psychiatric services.

239. On or about October 20, 1975, the Foundation's Board of Trustees discussed the Foundation's development of a relative value schedule for Arizona's doctors.

The Maricopa Foundation only admits that on or about October 20, 1975 its Board of Trustees discussed the Arizona relative value schedule that was being prepared by Patrick Moraca, M.D.

240. In or about December, 1975, *Round-Up* published a report on the adoption of the Foundation fee schedule for 1976.

The Maricopa Foundation has no information sufficient to admit or deny the truth or falsity of this statement and refers plaintiff to the response provided by the Maricopa Society.

241. In or about December, 1975, *Round-Up* published a report on the Foundation's development of a relative value schedule for Arizona doctors.

The Maricopa Foundation has no information sufficient to admit or deny the truth or falsity of this statement and refers plaintiff to the response provided by the Maricopa Society.

242. In or about December, 1975, *Round-Up* published a report on a pending lawsuit against the American Society of Anesthesiologists for a declaratory judgment against the use of relative value schedules.

The Maricopa Foundation has no information sufficient to admit or deny the truth or falsity of this statement and refers plaintiff to the response provided by the Maricopa Society.

243. On or about January 10, 1976, a representative of the Foundation described the Foundation's development of a relative value schedule for Arizona doctors at a meeting of the Board of Directors of the Arizona Medical Association.

The Maricopa Foundation is without information sufficient to admit or deny the truth or falsity of this statement.

244. Representatives of the county medical societies of Cochise, Coconino, Maricopa and Pima Counties, the Foundation and Pima Foundation attended the meeting of the Board of Directors of the Arizona Medican Association on or about January 10, 1976.

The Maricopa Foundation is without information sufficient to admit or deny the truth or falsity of this statement.

245. On or about January 13, 1976, the Society's Board of Directors elected three new trustees to the Foundation's Board of Trustees at a joint meeting of the Boards of Directors of the Society and the Bureau of Medical Economics.

The Maricopa Foundation only admits that in or about January 1976 its administrative members elected four new trustees to the Maricopa Foundation's Board of Trustees.

246. On or about February 6, 1976, the Foundation's Executive Director sent a written report to the Foundation's President outlining the course of action that culminated in the adoption of the Foundation fee schedule effective January 1, 1976.

Admit only that on or about February 6, 1976, Maricopa Foundation's Executive Director sent a written report to the Maricopa Foundation's President outlining the various

activities that culminated in adoption of new maximum levels of reimbursement payable to physicians for services rendered to patients insured under Maricopa Foundation-endorsed plans effective January 1, 1976.

247. On or about April 13, 1976, the Arizona Podiatry Association recommended five podiatrists to serve on the Foundation's review committee for podiatry services.

Admit.

248. On or about April 13, 1976, the podiatrists who were performing peer review for the Foundation met to discuss the unit values for various podiatry services.

Admit.

249. In or about June, 1976, the Foundation surveyed various groups of doctors concerning recommended increases in the Foundation fee schedule.

Denied. Upon information and belief, the Maricopa Foundation did not survey groups of doctors with respect to the Maricopa Foundation's conversion factors in or about June 1976. *See* response to statement 250 herein.

250. On or about June 6, 1976, the Arizona Society of Otolaryngology recommended a 10 percent increase in the Foundation fee schedule to 10.5.

The Maricopa Foundation only admits that by letter dated June 6, 1976, the Arizona Society of Otolaryngology recommended an increase in the surgical conversion factor used by Maricopa Foundation to determine the maximum level of reimbursement payable to doctors for surgical services performed on patients insured under a Maricopa Foundation-endorsed health insurance plan to a range of 10.0 to 11.0, which that society calculated to be an increase of approximately ten percent. The Maricopa Foundation further states that because of the location of said letter in its files, it believes that the author intended the date to be June 6, 1977.

251. On or about July 19, 1976, the Chairmen of the Foundation's Fee Schedule Committee reported to the Foundation's Board of Trustees on a meeting of said Chairman with plastic surgeons in the community concerning coverage of plastic surgery under Foundation Plans.

Admit.

252. On or about July 19, 1976, the Foundation's Board of Trustees appointed four plastic surgeons to a committee to make recommendations to the Board on coverage for plastic surgery under Foundation Plans.

Denied. The Maricopa Foundation admits that the minutes of its Board of Trustees dated July 19, 1976 reflect that four plastic surgeons were appointed by the plastic surgeons to outline to the Maricopa Foundation their recommendations for coverage of plastic surgery under the Maricopa Foundation minimum standards.

253. On or about August 13, 1976, the Foundation asked the Central Arizona Orthopedic Society for its opinion on the certification of in-patient benefits for ganglionectomy.

Admit.

254. From about 1973 until August 13, 1976 the Foundation denied inpatient benefits for ganglionectomies.

The Maricopa Foundation admits that the letter of Laurance B. Nilsen to Richard Daley dated August 13, 1976 reflects that it had been the policy of the Maricopa Foundation from 1973 to date to deny benefits for overnight hospitalization for simple ganglion resection.

255. On or about September 20, 1976, the Foundation's Board of Trustees discussed the unit value of 20 used by the Foundation for diagnostic laparoscopy.

Admit.

256. On or about September 20, 1976, the Foundation's Board of Trustees directed that the Foundation obtain the opinion of the Phoenix OB-GYN Society on the usual doctor's fee for diagnostic laparoscopy.

Admit.

257. On or about October 7, 1976, the Phoenix OB-GYN Society informed the Foundation of the unanimous agreement of members of the Phoenix OB-GYN Society that the unit value used by the Foundation for diagnostic laparoscopy should be increased from 20 to 35.

Admit.

258. On or about October 12, 1976, the Foundation's Board of Trustees referred to the Foundation's Fee Schedule Committee the opinion of the Phoenix OB-GYN Society on the usual doctor's fee for diagnostic laparoscopy.

Admit.

259. In or about November, 1976, the Foundation's Board of Trustees received a complaint from the President of the Arizona Internal Medicine Society that that Society had not been consulted with respect to the Foundation's 1976 fee schedule.

Admit only that in or about November 1976 the Foundation's Board of Trustees was informed by the President of the Arizona Internal Medicine Society that it had not been consulted with respect to the maximum level of reimbursement payable for services performed on patients insured under a Maricopa Foundation-endorsed health insurance plan proposed for 1976.

260. On or about November 19, 1976, the Foundation's Board of Trustees directed that the Internal Medicine Society should be consulted on the same basis as other doctors' groups before a new Foundation fee schedule was approved.

Admit only that on or about January 19, 1976 the Foundation's Board of Trustees decided that the Internal Medicine Society would be given an opportunity to discuss proposed changes in the maximum level of reimbursement payable for services performed on patients insured under a Maricopa Foundation-endorsed health insurance plan before such changes were submitted to the Foundation membership.

261. In or about November, 1976, the Foundation conducted a survey of fees charged for coronary bypass surgery among doctors who performed such surgery.

Admit only that in or about November 1976, Maricopa Foundation conducted a survey of fees charged in Maricopa County for coronary bypass surgery by doctors who perform such surgery.

262. On or about November 29, 1976, the Foundation's Physicians Review Committee recommended that the mean of the fees charged for corony bypass surgery be set as the allowable payment for such surgery under Foundation Plans.

Admit only that on or about November 29, 1976 Maricopa Foundation's Physicians Review Committee recommended that the mean of the usual and customary fees charged for coronary bypass surgery by doctors who perform such surgery in Maricopa County should be designated the maximum level of reimbursement payable to physicians for such surgery rendered to patients insured under Maricopa Foundation-endorsed plans.

263. In or about November, 1976, the Foundation's Board of Trustees set the unit values to be used by the Foundation for coronary bypass surgery, at 200 units for single bypass surgery, 225 units for double bypass surgery and 250 units for triple bypass surgery.

The Maricopa Foundation admits that the minutes of its Board of Trustees dated December 20, 1976 reflect that the Board adopted the above-stated unit values for the above-stated procedures.

264. At a joint meeting of the Boards of Directors of the Society and the Bureau of Medical Economics on or about December 14, 1976, the Society's Board of Directors elected nine trustees to three-year terms on the Foundation's Board of Trustees.

The Maricopa Foundation only admits that in or about December 1976 its administrative members elected nine new trustees to the Maricopa Foundation's Board of Trustees.

265. On or about December 17, 1976, the Chairman of the Foundation's Fee Schedule Committee directed the Foundation's staff to increase the Foundation's allowable fee for diagnostic laparoscopy.

The Maricopa Foundation only admits that on or about December 17, 1976 a Chairman of the Maricopa Foundation's Fee Schedule Committee left a telephone message for a Maricopa Foundation employee recommending that the Maricopa Foundation's maximum level of reimbursement for laparoscopy performed on patients insured under Maricopa Foundation-endorsed health insurance plans should be increased.

266. On or about December 22, 1976, the Chairman of the Procedures and Fees Committee of the Phoenix OB-GYN Society informed the Chairman of the Foundation's Physicians Review Committee that diagnostic laparoscopy should not be considered a routine procedure.

The Maricopa Foundation only admits that on or about December 22, 1976, the Chairman of the Procedure and Fees Committee of the Phoenix OB-GYN Society informed the Chairman of the Maricopa Foundation's Physicians

Review Committee that a pap smear is not a routine screening procedure "if obtained for colposcopically suggested or tissue proven dysplasia, carcinoma in situ, and invasive carcinoma of the vagina, vulva or cervix."

267. At a joint meeting of the Boards of Directors of the Society and the Bureau of Medical Economics on or about January 11, 1977, the Society's Board of Directors elected one trustee to fill a vacancy on the Foundation's Board of Trustees.

The Maricopa Foundation only admits that in or about January 1977 its administrative members elected one trustee to fill a vacancy on the Maricopa Foundation's Board of Trustees.

268. On or about February 21, 1977, the Foundation had 1,052 members.

Admit.

269. Between September, 1976 and February, 1977 the Phoenix OB-GYN Society surveyed its member on their prices for diagnostic laparoscopy and tubal laparoscopy and conveyed their responses to the Foundation.

Admitted.

270. The median fee for diagnostic laparoscopy reported in the survey of the Phoenix OB-GYN Society was $250.

Admit.

271. The average fee for diagnostic laparoscopy reported in the survey of the Phoenix OB-GYN Society was $266.05.

Admit.

272. On or about February 21, 1977, the Foundation's Board of Trustees set the Foundation's allowable fee for diagnostic laparoscopy at $275.

The Maricopa Foundation only admits that on or about February 21, 1977, its Board of Trustees voted to increase the unit value of diagnostic laparoscopy to 29 units which given the current conversion factor resulted in a maximum

level of reimbursement payable to physicians for a diagnostic laparoscopy of $275 for such a procedure on a patient insured under a Maricopa Foundation-endorsed plan.

273. The allowable fee for diagnostic laproscopy which the Foundation's Board of Trustees approved on or about February 21, 1977 had been recommended by the Phoenix OB-GYN Society.

Denied. On or about October 7, 1976, by letter from the president of the Phoenix OB-GYN Society to the Maricopa Foundation, that Society recommended that the unit value of a diagnostic laparoscopy be advanced to 35 units. On or about February 21, 1977, the Maricopa Foundation's Board of Trustees voted to set the unit value of diagnostic laparoscopies at 29 units.

274. The median fee for tubal laparoscopy reported in the survey of the Phoenix OB-GYN Society was $300.

Admit.

275. The average fee for tubal laparoscopy reported in the survey of the Phoenix OB-GYN Society was $315.53.

Admit.

276. On or about February 21, 1977, the Foundation's Board of Trustees set the Foundation's allowable fee for tubal laparoscopy at $325.

The Maricopa Foundation only admits that on or about February 21, 1977, its Board of Trustees voted to reduce the unit value for tubal ligation by laparoscopy to 34 units which given the current conversion factor resulted in a reduction in the maximum level of reimbursement payable to physicians for a tubal laparoscopy from $380 to $325 for such a procedure on a patient insured under a Maricopa Foundation-endorsed plan.

277. The allowable fee for tubal laparoscopy which the Foundation's Board of Trustees approved on or about February 21, 1977 had been recommended by the Phoenix OB-GYN Society.

Denied.

278. On or about March 17, 1977, the Foundation's Ad Hoc Finance Committee discussed various ways to spend the Foundation's excess funds, including continuation of the Foundation's development of a relative value schedule for Arizona doctors.

The Maricopa Foundation only admits that on or about March 7, 1977, the Maricopa Foundation's Ad Hoc Finance Committee discussed various ways to spend the Maricopa Foundation's accumulated funds including the establishment of a Foundation Relative Value Schedule.

279. On or about March 21, 1977, the Foundation's Board of Trustees agreed to consult various groups of doctors in April and May of 1977 concerning the Foundation fee schedule for 1978.

The Maricopa Foundation only admits that on or about March 21, 1977, its Board of Trustees directed that specialty societies be consulted in April and May of 1977 so that by June of 1977 the Board would have material available to determine new conversion factors to be used by the Maricopa Foundation to determine maximum levels of reimbursement payable to doctors for services performed on patients insured under a Maricopa Foundation-endorsed plan in the future.

280. On or about March 21, 1977, the Foundation's Board of Trustees agreed that the information needed to prepare the Foundation fee schedule for 1978 should be obtained by June, 1977.

See response to statement 279 herein.

281. On or about April 11, 1977, the Foundation asked various groups of doctors to review with their members the usual or customary fees their members charged.

The Maricopa Foundation only admits that on or about April 14, 1977, it asked various groups of doctors to review with their members the then-current conversion factors used by the Maricopa Foundation to determine maximum levels of reimbursement payable to doctors for services performed on patients insured under a Maricopa Foundation-endorsed plan and to advise the Maricopa Foundation of any changes the members thought would be appropriate.

282. On or about April 14, 1977, the Foundation asked various groups of doctors to report the results of their fee surveys to the Foundation so that the Foundation's new fee schedule would be as close as possible to the usual fees for doctor's services in the community.

The Maricopa Foundation only admits that on or about April 14, 1977 it asked various groups of doctors to review with their members the then-current conversion factors used by the Maricopa Foundation to determine maximum levels of reimbursement payable to doctors for services performed on patients insured under a Maricopa Foundation-endorsed plan and to advise the Maricopa Foundation of any changes the members thought would be appropriate in order to maintain as close-as-possible relationship between the maximum allowance for Maricopa Foundation-endorsed plans and the usual and customary charges made by physicians in the area.

283. On or about April 14, 1977, the Foundation asked the Procedures and Fees Committee of the Phoenix OB-GYN Society to determine the unit value that should be accorded a certain type of surgery.

The Maricopa Foundation only admits that on or about April 14, 1977 it asked the Procedures and Fees Committee of the Phoenix OB-GYN Society for advice with respect to the appropriateness of the relative value attributed a cer-

tain surgical procedure in the 1964 California Relative Value Schedule to determine maximum levels of reimbursement payable to doctors for services performed on patients insured under a Maricopa Foundation-endorsed plan.

284. On or about May 16, 1977, the Maricopa Plastic Surgeons informed the Foundation of a meeting they held at the Foundation's request.

The Maricopa Foundation only admits that on or about May 16, 1977 the Maricopa Plastic Surgeons Society informed the Maricopa Foundation that that group had held a recent meeting and that it had discussed a letter received by the group from the Medical Foundation's president.

285. On or about May 16, 1977, the Maricopa Plastic Surgeons recommended to the Foundation that the Foundation's unit conversion factor for surgery should be 10 and the Foundation should use the 1969 or 1974 edition (rather than the 1964 edition) of the California Relative Value Schedule.

Admit only that on or about May 16, 1977 the Maricopa Plastic Surgeons Society recommended to Maricopa Foundation that the conversion factor used by Maricopa Foundation for determining maximum levels of reimbursement payable to doctors for surgery performed on patients insured under a Maricopa Foundation-endorsed plan should be 10 and that the Maricopa Foundation should establish those maximum reimbursement levels with reference to the 1969 or 1974 edition of the California Relative Value Schedule rather than the 1964 edition.

286. On or about April 18, 1977, the Foundation's President reported to the Foundation's Board of Trustees that he had asked various doctors' groups to report to the Foundation the usual fees their members charged and their complaints regarding the Foundation fee schedule.

Admit only that on or about April 18, 1977 the Maricopa Foundation's President reported to its Board of Trustees that he had asked various doctors groups to report to the Maricopa Foundation as to the usual and customary fees of doctors in Maricopa County and to report any complaints regarding the maximum levels of reimbursement payable to doctors for services to patients insured under a Maricopa Foundation-endorsed plan.

287. On or about April 18, 1977, the Foundation's President informed the Foundation's Board of Trustees that preparation of the Foundation fee schedule for 1978 would begin after the Foundation received reports from various doctors' groups.

The Maricopa Foundation only admits that its president reported to its Board of Trustees that upon receiving information from the specialty societies, the Maricopa Foundation would discuss changes in the maximum levels of reimbursement payable to doctors for medical services performed on patients insured under a Maricopa Foundation-endorsed plan with its insurance advisors and make further reports to the Board.

288. On or about April 22, 1977, the President of the Phoenix Radiological Society reported to the Foundation that radiologists would not use a relative value schedule but would bill their own fees as required by a consent decree signed by the American College of Radiology.

The Maricopa Foundation only admits that by letter dated April 22, 1977 the president of the Phoenix Radiological Society informed the Maricopa Foundation that radiologists would bill their usual and customary fees without reference to a relative value schedule. No reference was made by the author of that letter to any consent decree signed by the American College of Radiology.

289. During the week of April 23, 1977, the Executive Director of the Foundation attended a discussion of the Federal Trade Commission's position that the use of relative value schedules by doctors is a violation of the federal antitrust laws.

Maricopa Foundation objects to this statement as beyond the scope of Rule 26(b).

290. On or about May 16, 1977, the Foundation's Board of Trustees declined to act on revision of the Foundation fee schedule because the Foundation's staff had not yet collated the opinions and reports of doctors' groups regarding such revisions.

Admit only that on or about May 16, 1977 the Maricopa Foundation's Board of Trustees determined that it should not revise the maximum levels of reimbursement payable to doctors for medical services performed on patients insured under a Maricopa Foundation-endorsed health insurance plan until information concerning usual and customary fees had been accumulated from medical specialty societies and others.

291. On or about May 24, 1977, the Phoenix Urology Society reported to the Foundation that a poll of its members showed that most charged a unit conversion factor of 10 to 11, a few charged 12, and one charged 9.5.

Admit only that on or about May 26, 1977 the President of the Phoenix Urological Society wrote to the President of Maricopa Foundation that a survey of its members revealed that most charged a usual and customary fee which would approximate a conversion factor of 10 to 11, a few would approximate 12 and one would approximate 9.5 using the equivalent of the 1964 California Relative Value Schedule.

292. On or about May 24, 1977, the Phoenix Urological Society reported to the Foundation that its members considered some procedures inadequately reimbursed under the relative conversion schedule used by the Foundation.

Admit only that on or about May 26, 1977 the President of the Phoenix Urological Society wrote to the President of Maricopa Foundation that its members considered some medical procedures inadequately reimbursed under the unit values used by Maricopa Foundation to determine maximum levels of reimbursement payable to doctors for services to patients insured under a Maricopa Foundation-endorsed health insurance plan.

293. On or about May 27, 1977, the President of the Arizona Society of Internal Medicine recommended to the Foundation that the unit conversion factor for medicine be increased _____ on the Foundation fee schedule for 1978.

Admit only that on or about May 27, 1977 the President of the Arizona Society of Internal Medicine wrote to Maricopa Foundation that the conversion factor used by Maricopa Foundation to determine maximum levels of reimbursement payable to doctors for medical services to patients insured under a Maricopa Foundation-endorsed health insurance plan should be increased in 1978.

294. On or about June 1, 1977, the premium on the Society's group insurance trust was doubled over the premium for the preceding year.

Admitted.

295. On or about June 6, 1977, the Chairman of the Phoenix OB-GYN Society reported to the Foundation that the Executive Committee of the Phoenix OB-GYN Society believed the unit conversion factor for medicine should be 10.5 on the Foundation fee schedule for 1978.

The Maricopa Foundation only admits that the Secretary-Treasurer of the Phoenix OB-GYN Society informed the Maricopa Foundation by letter dated June 6, 1977 that the Executive Committee of the Phoenix OB-GYN Society felt that the conversion factor for surgery used by Maricopa

Foundation to determine maximum levels of reimbursement payable to doctors for surgical services to patients insured under a Maricopa Foundation-endorsed health insurance plan should be increased to 10.50.

296. On or about June 6, 1977, the Chairman of the Phoenix OB-GYN Society reported to the Foundation the recommendation of the Procedures and Fees Committee of the Phoenix OB-GYN Society that the unit values accorded a certain surgical procedure on the relative value schedule used by the Foundation should be increased from to 50.

The Maricopa Foundation only admits that by letter dated June 6, 1977 the Chairman of the Procedures and Fees Committee of the Phoenix OB-GYN Society informed the Maricopa Foundation that it was the consensus of his committee that the relative value of the Marshall-Marchetti procedure used by Maricopa Foundation to determine maximum levels of reimbursement payable to doctors for performing the Marshall-Marchetti procedure on patients insured under a Maricopa Foundation-endorsed health insurance plan should be increased to 50.

297. On or about June 7, 1977, the Foundation sent questionnaires to Foundation members concerning their opinions on the Foundation fee schedule for 1978.

The Maricopa Foundation only admits that on or about June 7, 1977 the Maricopa Foundation surveyed its members asking them to indicate a single conversion factor in each member's practice category and relative value schedule which would approximate that member's usual and customary fees for medical services.

298. In or about June, 1977, the Foundation informed Foundation members that they would receive ballots for approval of a revised Foundation fee schedule as soon as the Foundation tabulated its membership poll.

Admit only that in or about June 1977 the Maricopa Foundation informed its members they would receive mail ballots to vote on the adoption of revised maximum reimbursable levels of compensation to doctors providing medical services to patients insured under Maricopa Foundation-endorsed health insurance plans as soon as the Maricopa Foundation tabulated the survey of usual and customary fees for medical services.

299. In or about June, 1977, the Foundation indicated to Foundation members that the Foundation fee schedule for 1978 should approximate the majority of doctors' charges.

The Maricopa Foundation only admits that by letter dated June 7, 1977 it stated to its membership that the Maricopa Foundation's maximum reimbursable levels of compensation to doctors providing medical services to patients insured under Maricopa Foundation-endorsed health insurance plans should approximate the majority of physician charges "but could not be considered usual and customary fees for medical services in Maricopa County."

300. On or about June 17, 1977, the Gastrointestinal Association suggested a conversion factor of 11 for medicine on the Foundation fee schedule for 1978.

The Maricopa Foundation only admits that on or about June 17, 1977 a letter was written by four physicians doing business as Gastrointestinal Associates, P.A. suggesting that medical diagnostic procedures listed under surgery should be reclassified under medicine and be allotted a conversion factor of 11 for the purpose of determining the Maricopa Foundation's maximum reimbursable levels of compensation to doctors performing those procedures on patients insured under Maricopa Foundation-endorsed health insurance plans.

301. On or about June 21, 1977, the Foundation's Board of Trustees heard a report on its fee survey of Foundation members.

Admit only that on or about June 21, 1977 the Board of Trustees of Maricopa Foundation received a report on its survey of Maricopa Foundation members as to their usual and customary fees for medical services.

302. On or about June 21, 1977, the Foundation's Board of Trustees discussed various methods of increasing the Foundation fee schedule for 1978.

Admit only that on or about June 21, 1977 the Board of Trustees of the Maricopa Foundation discussed various methods of increasing the Maricopa Foundation's maximum reimbursable levels of compensation to doctors providing medical services to patients insured under Maricopa Foundation-endorsed health insurance plans.

303. A Foundation fee schedule effective December 1, 1977 was adopted in or before October, 1977.

Admit only that in or before October 1977 Maricopa Foundation adopted revised maximum reimbursable levels of compensation to doctors providing medical services to patients insured under Maricopa Foundation-endorsed health insurance plans effective December 1, 1977.

304. The Foundation fee schedule effective December 1, 1977 included unit conversion factors of:

(a) 12.25 for medicine;
(b) 10.50 for surgery;
(c) 7.50 for laboratory;
(d) 8.50 for radiology with a professional component of $1.85;
(e) 13.25 for anesthesiology.

Admit only that the conversion factors used by Maricopa Foundation to calculate maximum reimbursable levels of compensation payable by the insurer to doctors for services provided to patients insured under Maricopa Foundation-endorsed health insurance plans effective December 1, 1977 are as stated in statement 304.

305. In or about September, 1977, Foundation representative(s) discussed changes in the Foundation's criteria for podiatry claims with members of the Foundation's Peer Review Committee for Podiatry.

The Maricopa Foundation only admits that on or about December 21, 1977 it transmitted criteria for podiatry peer review to the chairman of the Maricopa Foundation's Peer Review Committee for Podiatry.

306. The members of the Foundation's Peer Review Committee for Podiatry had been nominated by the Arizona Podiatry Association.

The Maricopa Foundation only admits that some of the persons nominated by the Arizona Podiatry Association by letter dated April 13, 1976 from the Secretary of the Arizona Podiatry Association to the Maricopa Foundation served on the Maricopa Foundation's Peer Review Committee for Podiatry.

307. On or about January 26, 1978, the Foundation's Executive Director informed the Arizona Director of Insurance that is no case does the Foundation act as an insurer or write checks on its own account in payment of claims under Foundation Plans.

The Maricopa Foundation admits that on or about January 26, 1978, its Executive Director informed the Arizona Director of Insurance that "[i]n no case does the Foundation act as an insurance company or write checks on its own account" in payment of claims for services rendered to patients insured under Maricopa Foundation-endorsed plans.

308. On or about December 13, 1977, the Society's Board of Directors elected seven trustees to three-year terms on the Foundation's Board of Trustees.

The Maricopa Foundation only admits that in or about December 1977, its administrative members elected seven new trustees to the Maricopa Foundation's Board of Trustees.

309. The Society is an association of doctors in Maricopa County, Arizona.

The Maricopa Foundation has no information sufficient to admit or deny the truth or falsity of this statement and refers plaintiff to the response provided by the Maricopa County Medical Society.

310. The Foundation's participating members are doctors who are qualified to be or are active members of the Society or another county medical society in the State of Arizona or the Arizona Osteopathic Society.

The Maricopa Foundation only admits that to qualify as a participating member of the Maricopa Foundation, a physician must be licensed to practice medicine or osteopathy in Arizona.

311. The Foundation's cooperating members are members of the Arizona Podiatry Society or the Arizona Society of Oral Surgeons.

The Maricopa Foundation only admits that to qualify as a cooperating member of the Maricopa Foundation, a doctor must be licensed to practice podiatry or oral surgery in Arizona.

312. The Foundation's PSRO members are providers of medical services to Federal Medicare patients.

Denied. The Maricopa Foundation has no such member classification. *See* the By-Laws of the Maricopa Foundation revised as of August 14, 1977 produced to plaintiff on April 7, 1978.

313. Over 70 per cent of the doctors practicing in Maricopa County are Foundation members.

The Maricopa Foundation is without knowledge or information sufficient to admit or deny the truth or falsity of this statement with respect to the number of doctors who are practicing in Maricopa County, Arizona.

314. The Executive Director of the Society is also the Executive Director of the Foundation.

Admit.

315. The principal place of business of the Foundation and principal place of business of the Society are located in the same building.

Admit only that Maricopa Foundation and Maricopa Society have separate offices which are their separate principal places of business and that both are located in the same complex of offices.

* * * *

(Signature omitted in printing.)

EXHIBIT C

(Caption omitted in printing.)

DEFENDANT MARICOPA COUNTY MEDICAL SOCIETY'S RESPONSES TO PLAINTIFF'S FIRST REQUEST FOR ADMISSIONS AND INTERROGATORIES

* * * *

2. The members' of the Board of Directors of the Society are elected by the members of the Society.

ANSWER: Admit

3. The Members of the Board of Directors of the Society automatically become administrative members of the Foundation.

ANSWER: Admit

4. Administrative members are the only class of members in the Foundation having a general voting power.

ANSWER: N.A.

5. As the administrative members of the Foundation, the members of the Board of Directors of the Society elect or appoint the members of the Board of Trustees of the Foundation.

ANSWER: Admit

* * * *

308. On or about December 13, 1977, the Society's Board of Directors elected seven trustees to three-year terms on the Foundation's Board of Trustees.

ANSWER: Admit

309. The Society is an association of doctors in Maricopa County, Arizona.

ANSWER: The Maricopa Society admits only that it is a non-profit corporation whose members are licensed physicians.

* * * *

314. The Executive Director of the Society is also the Executive Director of the Foundation.

ANSWER: Admit

315. The principal place of business of the Foundation and principal place of business of the Society are located in the same building.

ANSWER: Admit

* * * *

(Signatures omitted in printing.)

EXHIBIT D

[Attorney Correspondence and Stipulations with Respect to Exhibits]

(Contents omitted in printing.)

EXHIBIT E

Maricopa Foundation for Medical Care 1970 [containing California Relative Value Studies]

(Contents omitted in printing.)

EXHIBIT F

Radiology Relative Values

(Contents omitted in printing.)

EXHIBIT G

American Society of Anesthesiologists, Relative Value Guide 1973

(Contents omitted in printing.)

EXHIBIT H

California Relative Value Schedule Conversion Manual 1974-1969-1964

(Contents omitted in printing.)

EXHIBIT I

Maricopa Foundation for Medical Care Conversion Factors for all New or Renewed Groups after December 1, 1977

(Contents omitted in printing.)

No. 80-419

Office Supreme Court, U.S.
JUN 10 1981

IN THE
Supreme Court of the United States
OCTOBER TERM, 1980

STATE OF ARIZONA,
Petitioner,

vs.

MARICOPA COUNTY MEDICAL SOCIETY,
MARICOPA FOUNDATION FOR MEDICAL CARE, and
Pima Foundation For Medical Care,
Respondents.

ON WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE NINTH CIRCUIT

JOINT APPENDIX

Vol. 2 Pages 275-541

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Society

PETITION FOR CERTIORARI FILED SEPTEMBER 16, 1980
CERTIORARI GRANTED MARCH 9, 1981

EXHIBIT J

EXHBT. 31 FOR I D
HOLIDAY & ASSOCIATES
KENNETH R. MILLER
DATE 11-22-78
(Mitten Depo)

MARICOPA FOUNDATION FOR MEDICAL CARE

September 30, 1977

TO: All Foundation Doctors

Dear Doctor:

Enclosed is a ballot which asks your opinion of a proposed increase in the conversion factors used by the Foundation. If these increases are approved by a simple majority, they will become effective December 1, 1977 for all insurance plans initiated or renewed after that date.

Since its inception in 1969, the Foundation has attempted to convince the public that private practice, fee-for-service medicine is not only superior in regard to patient care, but is also cost effective. Because we have all been faced with increased expenses we are necessarily forced to consider a change in the fee schedules we use. We urge you to voice your feelings by responding with this ballot.

In the near future you will be receiving an application for participation in the Foundation in the calendar year 1978. We hope you will continue to support the Foundation concepts and activities. The Board of Trustees sincerely appreciate comments concerning any aspect of the Foundation operation.

Sincerely,

Lawrence J. Shapiro, M.D.
PRESIDENT

LJS:lm

Enclosure

MARICOPA FOUNDATION FEE SCHEDULE BALLOT

Based on the California Medical Association's Relative Value Study of 1964, the conversion factors should be as follows:

$10.50 per unit for surgery
$12.25 per unit for medicine and pathology
$ 7.50 per unit for clinical laboratory
$13.25 per unit for anesthesiology (based on the 1973 ASA Guide)
$ 8.50 per unit for radiology (based on the ACR, 1973)

( ) YES ( ) NO

If you decide to vote no we would appreciate your comments:

Name (please print)

EXHIBIT K

EXHBT. 34 FOR I D
HOLIDAY & ASSOCIATES
KENNETH R. MILLER
DATE 11-22-78
(Mitten Depo)

MINUTES

MARICOPA FOUNDATION FOR MEDICAL CARE

BOARD OF TRUSTEES

October 17, 1977

PRESENT: Doctors: Norman Brown, M.D., James Campbell, M.D., Richard Daley, M.D., Robert Diserens, M.D., Keith Harris, M.D., Rudger Hiatt, M.D., James Laugharn, M.D., Donald Miles, M.D., Patrick P. Moraca, M.D., William Myers, M.D., Lawrence J. Shapiro, M.D., and Ronald Suiter, M.D.

Guests: Doctors Herbert Brown, M.D., Ira B. Ehrlich, M.D., Neil Ward, M.D., Mr. Anthony D. Mitten and Mrs. Dwyn Keller.

MINUTES: The minutes of the September 19, 1977 Board of Trustees meeting were reviewed and accepted as submitted.

FINANCIAL REPORT: The financial report for September was discussed at length and approved as submitted.

FEE SCHEDULE BALLOT: The ballot report indicated a majority of the ballots returned with 691 members approving the following conversion factors. $10.50 per unit for surgery, $12.25 per unit for medicine and pathology, $7.50 per unit for clinical laboratory, $13.25 per unit for anesthesiology (based on the 1973 ASA Guide), $8.50 per unit for radiology (based on the ACR, 1973).

A letter from Don Schaller, M.D. was read. The content of this letter was felt to be erroneous in nature since the increase is only 5% over a two year period of time.

AAFMC DUES: The billing for the annual American Association of Foundations for Medical Care dues in the amount of $680.00 was approved for payment.

ARIZONA PIPE TRADES UNION: The proposal submitted by Martin Segal Company for Foundation sponorship, CHAP and Peer Review was discussed. It was the consensus of the Board to investigate the conversion factors used for payment to non-member physicians and to obtain a more concrete proposal showing a comparison of the conversion factors for the next Board meeting.

PSRO: George Stavros, M.D. has been nominated to serve as Executive Medical Director for the Northern Arizona Medical Evaluation Systems PSRO during the planning period of the PSRO grant. He will submit a schedule outlining the duties to be undertaken in the performance of this job.

EXHIBIT L

PIMA FOUNDATION FOR MEDICAL CARE

MAXIMUM FEE SCHEDULE FOR PREVENTATIVE CHILD CARE

Newborn Care (routine)	$35.00
Well infant or Well child office visits	12.00
DPT	5.00
Tri Sabin Oral Polio	5.00
PPD skin test	5.00
Cocci skin test	5.00
Hemoglobin or Hematocrit	2.50
Urinalysis	4.50
Measles, Mumps or Rubella (separately)	10.00
Combination of two where available (Mumps-Rubella or Measles-Rubella)	15.00
MMR (Measles-Mumps-Rubella)	20.00

EXHIBIT M

MINUTES

MARICOPA FOUNDATION FOR MEDICAL CARE

FEE REIMBURSEMENT COMMITTEE

May 22, 1978

PRESENT: Doctors: Richard Daley, M.D., John Kelley, M.D., Richard Pendergast, Robert Fox, M.D., Norman Brown, M.D., Keith Harris, M.D., Lawrence Shapiro, M.D., Laurance Nilsen, M.D. and William Devine, D.O.

Staff: Anthony D. Mitten and Dwyn Keller

The goals of this committee were discussed and several methods were considered to accomplish the Board directive to upgrade the present method of identifying services to the Foundation for payment.

This committee approved using the 1974 RVS complete with unit values. Each specialty is to establish a conversion factor to use with 1974 RVS that will reflect the current Foundation payment. This recommendation will be brought to the June 19, 1978 Foundation Board meeting.

Doctor Harris requested each member to also list the procedures that were gross inequities and bring these to the next meeting of this committee for consideration prior to requesting Board approval of any charges.

This committee will meet again on June 26, 1978 to discuss acceptable conversion factors.

There being no further business, the meeting was adjourned at 8:00 p.m.

Respectfully sumitted,

Keith Harris, M.D.
Chairman

EXHIBIT N

BY-LAWS
OF
PIMA FOUNDATION FOR MEDICAL CARE

CHAPTER I
GENERAL PROVISIONS AND PROPERTY INTERESTS

Section 1. Business to be conducted without profit: This corporation shall conduct and carry on its business without profit to itself or its members, or any class thereof. No member of this corporation shall, by reason of membership herein, be or become entitled at any time to receive any assets, property, income, or earnings from the corporation, or to profit therefrom in any manner.

Section 2. Use of income: All of the income, revenue, and earnings of the corporation shall be held, used, managed, devoted, expended and applied in the discretion and judgment of the Trustees, to carry out the objects and purposes of the corporation, and without profit, direct or indirect, to any member of the corporation as such.

Section 3. Distribution of assets on dissolution: In the event of the dissolution of this corporation, all of its assets and property, after payment and satisfaction of all claims and demands against the corporation and all liabilities of the corporation, shall be conveyed and transferred to such non-profit, charitable organization as the Board of Trustees of this corporation shall determine.

CHAPTER II
MEMBERSHIP

Section 1. Classes of membership: There shall be only one class of membership in this corporation. It shall be known as Corporate Members. Any physician who has previously

applied for and been accepted as a Participating or a Cooperating Member shall hereafter be a Corporate Member until his membership shall be terminated as provided in these By-Laws.

Section 2. Qualifications of Corporate Members: Any physician or podiatrist authorized by the statutes of the State of Arizona to practice medicine in the State of Arizona, who practices in Pima County or a county contiguous to Pima County shall be eligible to apply for membership as a Corporate Member. This membership may be granted by the Board of Trustees to any such person so qualified upon making application therefor. The dues and assessments to be charged for admission to Corporate Membership, or to be imposed upon members shall be determined by the Board of Trustees.

Section 3. Rights and privileges of Corporate Members: Corporate Members shall have the right to vote on the adoption of any contract limits for medical services by the Foundation. Adoption of any such schedule for medical services shall be by mail ballot. A simple affirmative majority of those ballots received shall be required for adoption. On any such issue submitted to the Corporate Members, the voting power of Corporate Members shall be equal to that of every other entitled to one vote on issues submitted to the Corporate Members. Both cumulative and proxy voting are expressly prohibited. Adoption of any contract limits by the membership notwithstanding. The Board of Trustees may negotiate health care contracts on behalf of the Foundation and such contracts will be binding on the Foundation, even though they may represent a variance or potential variance from the established contract limits. In such cases, however, the membership must be polled regarding the acceptability of the contract limits within a reasonable time, and in no event to exceed one year from

the date of such contracts. Voting shall be by mail ballot and the results of the voting will be a determining factor to be considered by the Trustees in re-negotiating the contracts in question.

Section 4. Term of membership: Corporate Membership shall be for a five (5) year period of time. Membership may be determined by (A) Voluntary request in writing by the Corporate Member to resign his membership submitted to the Board of Trustees to become effective January 1, of the following year; or (B) involuntary termination as initiated and undertaken according to Chapter XII, Section 8, of these By-Laws.

Section 5. Procedure for admission to Corporate Membership: Any person who desires to become a Corporate Member of this corporation shall fill out and sign in duplicate the application blank provided for that purpose by the corporation. Such application blank shall be in the form or forms determined by the Board of Trustees, and shall contain a clause stating in substance that the applicant agrees to be bound by the constitution, By-Laws, and rules and regulations of this corporation; that said applicant agrees to be bound by the principles of professional conduct of this corporation; that the applicant, as long as his membership in this corporation is effective, agrees to be bound by any and all rules, regulations, committee decisions, contract limits, and the like, adopted by this corporation.

Said application shall be filed with the secretary-treasurer at the principal office of the corporation. The application shall be referred by the secretary-treasurer to the Membership Committee, which shall investigate the background and present status of the applicant, and shall report to the Board of Trustees, with a recommendation, thereon. At the next meeting of the Board of Trustees, the president shall announce the names of those applicants submitted to it by the Membership Committee, and the committee recommen-

dation, if any. Each applicant shall thereupon be voted on individually; and it shall require a two-thirds majority vote of the Board of Trustees to elect to membership.

Section 6. Non-transferability of membership: Neither Corporate Membership in this corporation nor any certificate evidencing the same nor the interest of any Corporate Member in this corporation, or any of the assets thereof, shall (A) be subject to execution or become or be an asset of the estate of any deceased member, or of any member who may become insolvent or bankrupt, (B) descend to or vest in the heirs, legatees, or devisees or any member, or (C) be transferable or assignable in any form either by the voluntary or by the involuntary act of any member, or by operation of law. In the event of the death, insolvency or bankruptcy of any member of this corporation or of any certificate evidencing the same or of any interest of any member in this corporation, or any of the assets thereof, whether by the voluntary act of the member or otherwise, such membership certificates and all interests of any such member in this corporation and all assets thereof shall be immediately cancelled, revoked and terminated.

Section 7. Membership roll: A written record of the Corporate Membership of this corporation shall be kept by the secretary and said record shall contain the name and address of each Corporate Member, and in any case where any membership has been terminated for any reason whatsoever, an entry of such fact, together with the date upon which said membership was so terminated.

CHAPTER III
CERTIFICATES OF MEMBERSHIP

Section 1. Certificates: Certificates of membership shall be of such form and device as the Board of Trustees may prescribe. Each certificate shall express on its face the year issued, and person to whom it is issued. Certificates of membership shall be non-transferable. Issuance to and acceptance by a member of such certificate of membership shall be conclusive evidence of the consent of the member

to become a Corporate Member of this corporation, and of this agreement to comply with and be governed by all the provisions of the articles of incorporation, By-Laws and rules and regulations of this corporation. Certificates of membership in this corporation shall be cancelled by the secretary whenever a member ceases to be eligible as such, or whenever the membership of the member terminates, in accordance with the provisions of the articles of incorporation, or these By-Laws. All certificates of membership shall be signed by the president or vice-president and by the secretary of this corporation.

CHAPTER IV
MEETING OF MEMBERS

Section 1. Annual meetings; Annual meetings of all members shall be held on the second Tuesday of December in a location to be designated by the Board of Trustees. Notice of all annual meetings of members will be given to all members.

Section 2. Regular meetings: Regular meetings of the Board of Trustees shall be held monthly at the corporate offices of the organization.

Section 3. Special meetings: Special meetings of Corporate Members, for any purpose or purposes whatsoever, may be called at any time by the president or the Board of Trustees; or by one-third of the members. Notice of special meetings shall be given to each member entitled to vote thereat either personally or by mail addressed to such member at his address appearing upon the books of the corporation at least ten (10) days in advance of the date of such special meetings; and such written notice shall also state the place, day and hour of such meeting and general nature of the business to be transacted. No business shall be transacted at a special meeting other than stated in the purposes set forth in the notice. Special meetings may be held at the principal office of the corporation or at any other place within Pima County, State of Arizona.

Section 4. Adjourned meetings and notice thereof: Any members' meeting, annual or special, whether or not a quorum is present, may be adjourned from time to time by the vote of a majority of the members who are present in person; but in the absence of a quorum, no other business may be transacted at any such meeting. A quorum shall consist of twenty-percent (20%) of the Corporate Membership of the corporation.

When any members' meeting, either regular, annual or special, is adjourned for thirty (30) days or more, notice of the adjourned meeting shall be given as in the case of an original meeting. Save as aforesaid, it shall not be necessary to give notice of any adjournment or of the business to be transacted at any adjourned meeting, other than by an announcement at the meeting at which such adjournment is taken.

Section 5. Entry of notice: Whenever any member entitled to vote has been absent from any special meeting of members, or a class thereof, an entry in the minutes to the effect that notice has been duly given shall be conclusive and incontrovertible evidence that due notice of such meeting was given to such member or members as required by law and the By-Laws of this corporation.

Section 6. Consent of absentees: The transaction of any meeting of members, or a class thereof, either regular, annual, or special, however called and noticed, shall be as valid as though had a meeting duly been held after regular call and notice if a quorum be present in person, sign a written waiver of notice or consent to the holding of such meeting or an approval of the minutes thereof. All such waivers, consents, or approvals shall be filed with the corporate records or made a part of the minutes of the meeting.

Section 7. Action without meeting: Any action which may be taken at a meeting of the members, or a class thereof, may be taken without a meeting if authorized by a writing signed by all of the members who would be entitled to vote at a meeting of such purpose, and filed with the secretary of the corporation.

CHAPTER V
CORPORATE POWERS

Section 1. Corporate powers vested in Board of Trustees: The corporate powers of this corporation shall be vested in a Board of at least twelve (12) Trustees. Two-thirds of said Trustees shall constitute a quorum for the transaction of business.

Section 2. Powers of Trustees: Subject to these By-Laws, the Board of Trustees shall have full and sole power to control and manage the property and conduct the affairs and business of this corporation; and in furtherance of the foregoing powers, but not in limitation thereof, it shall have power:

First: To select and remove all the other officers, agents and employees of the corporation, prescribe such powers and duties for them as may not be inconsistent with law, with the articles of incorporation, or with these By-Laws; fix their compensation; and require from them security for faithful service.

Second: To conduct, manage and control the affairs and business of the corporation; and to make such rules and regulations therefore not inconsistent with law, with the articles of incorporation, or with these By-Laws, as they may deem best.

Third: To procure the membership application forms and membership certificate forms; and to alter such membership application forms and membership certificates from time to time.

Fourth: To make assessments, borrow money and incur indebtedness for the purpose of the corporation; and to cause to be executed and delivered therefor in the corporation name promissory notes, bonds, deben-

tures, deeds of trust, mortgages, pledges, hypothecations, or other evidences of debt and securities therefor subject only to concurrence of two-thirds of the Board of Trustees.

Fifth: To appoint an executive committee and other committees, and to delegate to the executive committee any of the power and authority of the Trustees in the management of the business and affairs of the corporation, except the power to adopt, amend, or repeal By-Laws. The executive committee shall be composed of three or more Trustees of this corporation and membership therein is expressly limited to Trustees.

Sixth: to appoint and employ an executive secretary or manager, and any subordinate officials and employees.

Seventh: To consider, approve or disapprove all recommendations of any committee; and to adopt and to propose to the Corporate Members contract limits for medical services, which when adopted by a majority vote of the Corporate Membership shall be binding upon all Corporate Members of this Corporation while, and so long as they are Corporate Members in good standing of this corporation.

CHAPTER VI
BOARD OF TRUSTEES

Section 1. Terms of office: The first Trustees designated as such in the articles of this corporation shall hold office and exercise all powers granted to the Board of Trustees until the next regular annual meeting of the Corporate Members of this corporation. Thereafter, a new Board of Trustees shall be elected by the Corporate Members in accordance with these By-Laws. The new Board of Trustees so elected may be composed of all, some, or none of the first Trustees designated as such in the articles of incorporation. Four (4) members of said Board of Trustees shall be elected for a period of three (3) years; four (4) for a period of two (2) years; and four (4) for a period of one (1) year. Yearly

thereafter, four (4) new members shall be elected to the Board of Trustees of this corporation for a period of three (3) years. No more than three (3) consecutive terms may be served by any one individual.

Section 2. Removal from office: Any Trustee may be removed from office as such by the affirmative vote of two-thirds of the members, at any annual or special meeting of the members, on written notice satting forth the reasons and ground therefor, mailed to such Trustee at his last known address at least ten (10) days prior to the date of such meeting. Three (3) consecutive unexcused or four (4) unexcused absences in any twelve (12) months shall be sufficient grounds for summary dismissal from the Board of Trustees.

Section 3. Vacancies: In the event of a vacancy on the Board of Trustees, the vancancy shall be filled by a majority vote of the Board of Trustees for the remainder of the vacancy term.

Section 4. Amendment for expansion of Board: The Board of Trustees of this corporation shall be composed of at least twelve (12) persons, two-thirds (⅔) of whom must be Corporate Members of this corporation. One-third (⅓) may be lay (non-physician) individuals from the Pima County, Arizona community selected for their interest in the provisions of quality health services to the community compatible with the philosophy, objectives and ethics of the Pima Foundation for Medical care. Initially one-third (⅓) of lay-members will be elected for three (3) years, one-third (⅓) for two (2) years and one-third (⅓) for one (1) year, and yearly thereafter each lay-member will be lected for three (3) year periods.

CHAPTER VII
MEETINGS

Section 1. Regular meetings: Regular meetings of the Board of Trustees shall be held. The scheduled time and location of such meetings shall be at the office of the Pima Foundation for Medical Care.

Section 2. Special meetings: Special meetings of the Board of Trustees for any purposes shall be called at any time by the president, or any three (3) Trustees. Written notice of the time and place of special meetings shall be delivered or sent to each Trustee at his address as it is shown upon the books of the corporation. In such case notice is mailed, it shall be deposited in the United States mail at least seventy-two (72) hours before the time of the holding of the meeting. Mailing or delivering shall be due, legal and personal notice of such Trustees.

Section 3. Written consents and waiver of notice: The transactions of any meetings of the Board of Trustees, however called and noticed, or wherever held, shall be as valid as though had a meeting duly been held after regular call and notice. If a quorum be present, and if, either before or after the meeting, each of the Trustees not present sign a written waiver of notice or consent to holding such meeting or an approval of the minutes thereof. All such waivers, consents, or approvals shall be filed with the corporate records and made a part of the minutes of the meeting.

CHAPTER VIII
OFFICERS

Section 1. Officers: The officers of this corporation shall be a president, a vice-president, a secretary, a treasurer, and such other officers as the Board of Trustees may appoint.

Section 2. Election: The officers of the corporation shall be chosen annually by the Board of Trustees from its membership at its organization meeting, and each shall hold his office until he shall resign or shall be removed or otherwise disqualified to serve, or his successor shall be elected and qualified.

Section 3. Removal and resignation: Any officer may be removed, either with or without cause, by a majority of the Trustees in office at the time, at any regular or special meeting of the Board. Any officer may resign at any time by giving written notice to the Board of Trustees or to the president or to the secretary of the corporation. Any such resignation shall take effect at the date of the receipt of such notice or at any later time specified therein; and unless otherwise specified therein, the acceptance of such resignation shall not be necessary to make it effective.

Section 4. Vacancies: A vacancy in any office because of death, resignation, removal, disqualification, or any other cause shall be filled by the Board of Trustees until the next annual election of officers.

CHAPTER IX
DUTIES OF OFFICERS

Section 1. President: The president shall be the chief executive officer of the corporation, and shall, subject to the control of the Trustees, have general supervision, direction, and control of the business and officers of the corporation. He shall preside at all meetings of the members and at all meetings of the Trustees. He shall be at all meetings of the members and at all meetings of the Trustees. He shall be ex-officio a member of all the standing committees including the executive committee, if any, and shall have the general powers and duties of management usually vested in the office of the president of a corporation, and shall have such other powers and duties as may be prescribed by the Board of Trustees or these By-Laws.

Section 2. Vice-President: In the absence or disability of the president, the vice-presidents in order of their rank as fixed by the Board of Trustees—or, if not ranked, the vice-president designated by the Board of Trustees—shall perform all the duties of the president, and when so acting, shall have all the powers of, and be subject to, all the restrictions upon the president. The vice-president shall have such other powers and perform such other duties as from time to time may be prescribed for them respectively by the Trustees or by these By-Laws.

Section 3. Secretary: The secretary shall keep, or cause to be kept, a book of minutes at the principal office of the corporation, or such other place as the Board of Trustees may order, of all meetings of the Board of Trustees and Corporate Members, with the time and place of holding, whether special or regular, and if special, how authorized, the notice thereon given, the names of those present at Board meetings, the number of members present at members' meetings, and the proceedings thereof. He shall also keep and maintain the membership certificate book and membership roll of the membership of this corporation, and records of all terminations of memberships in this corporation.

The Secretary shall give, or cause to be given, notice of all the meetings of members and of the Trustees required by these By-Laws or by the law to be given and he shall have such other powers and perform such other duties as may be prescribed by the Board of Trustees or by these By-Laws.

Section 4. Treasurer: The treasurer shall keep and maintain, or cause to be kept and maintained, adequate and correct accounts of the properties and business transactions of the corporation, including accounts of its assets, liabilities, receipts, disbursements, gains and losses.

The treasurer shall deposit all monies and other valuables in the name and to the credit of the corporation with such depositaries as may be designated by the Board of Trustees. He shall disburse the funds of the corporation as may be

ordered by the Board of Trustees; shall render to the president and the Board of Trustees, whenever they request it, an account of all his transactions as treasurer, and of the financial condition of the corporation; and shall have such other powers and perform such other duties as may be prescribed by the Board of Trustees or by these By-Laws.

CHAPTER X
EXECUTIVE COMMITTEE AND OTHER COMMITTEES ESTABLISHED BY TRUSTEES

Section 1. Executive Committee: There is hereby created an executive committee to consist of the president, the vice-president, the secretary, and the treasurer of the corporation. Such executive committee shall be vested with all of the powers of the Board of Trustees when the Board of Trustees is not in session.

Section 2. Standing committees: Standing committees of this corporation shall be as follows:

A. Constitution and By-Laws Committee

B. Membership Committee

C. Actuarial Advisory Committee

D. Minimum Standards Committee

E. Peer Review Committee

Section 3. Qualifications and terms of office of committee members: The members of the committees shall be appointed by the president, subject to the approval of the Board of Trustees, and shall hold office for a period of one year.

Section 4. Composition and duties of committees: Each standing committee shall have as many members thereon as the Board of Trustees may from time to time determine, and shall have such duties and perform such functions as may be required of them by the Board of Trustees from time to time.

Section 5. Other committees: The Board of Trustees may from time to time create other standing and special committees, appoint the numbers thereof, and invest therein such powers and duties as it may deem desirable.

CHAPTER XI
ELECTIONS

Section 1. Board of Trustees: The Corporate Members of this corporation shall elect, by a majority vote, and in accordance with these By-Laws and the articles of incorporation, the Board of Trustees of this corporation. The Nominating Committee shall present to the membership forty-five (45) days prior to date of election at least one nominee for each vacancy on the Board of Trustees. Each nominee must have agreed to accept the nomination. These nominations will be mailed to the membership at least thirty (30) days prior to election. Nominations may be made by the membership. The nomination must be made by five Corporate Members and the nominee must have agreed to accept the nomination. Election will be made by mail ballot sent fourteen (14) days prior to the date of election, and the counting of ballots which will coincide with the date of the annual meeting.

Section 2. Officers: The Board of Trustees of this corporation, at the next regular meeting following their election to said Board, shall by simple majority vote, and in accordance with these By-Laws, elect the officers of this corporation.

CHAPTER XII
MISCELLANEOUS

Section 1. Inspection of corporate records: The membership roll or register or duplicate membership roll or register, the books of accounts, and the minutes of proceedings of members and Trustees shall be open to inspection upon written demand of any Corporate Member at any reasonable time, and for a purpose reasonable related to his interest as such member and shall be exhibited at any time when required by the demand of ten (10) percent of the members. De-

mand of inspection other than that at a members' meeting shall be made in writing upon the president, or the secretary.

Section 2. Checks, drafts, etc: All checks, drafts, or other order for payment of money, notes, or other evidences of indebtedness issued in the name or payable to the corporation shall be signed or endorsed by such person or persons, and in such manner, as from time to time shall be determined by resolution of the Board of Trustees.

Section 3. Annual Report: The Board of Trustees shall cause to be sent to the members, not later than one hundred twenty (120) days after the close of the fiscal or calendar year, an annual report of the financial affairs of the corporation.

Section 4. Contracts, etc. - how executed: The Board of Trustees, except as in these By-Laws otherwise provided, may authorize any officer or officers, agent or agents to enter into any contract or to execute any instrument in the name of any on behalf of the corporation, and such authority may be general or confined to specific instances. Unless so authorized by the Board of Trustees, no officer, agent, or employee shall have any power or authority to bind the corporation by any contract or engagement, or to pledge its credit to render it liable for any purpose or to any amount.

Section 5. Inspection of By-Laws: The corporation shall keep in its principal office for the transaction of business the original or a copy of the By-Laws as amended or otherwise altered to date, certified by the secretary, which shall be open to inspection by the members at all reasonable times during office hours.

Section 6. Rules of order: Roberts' Rules of Order shall be the parliamentary guide when not in conflict with the articles of incorporation or these By-Laws.

Section 7. Rules of Professional conduct: Principles of Professional Conduct as this corporation may adopt by a majority vote of its members shall govern this corporation and all members thereof.

Section 8. Disciplinary Action: A member who is guilty of a criminal offense or gross misconduct, either as a physician or as a citizen, or violates any of the provisions of the articles of incorporation of this corporation, or these By-Laws, or who acts contrary to or in violation of any contracts, agreements, or statements of principle of this corporation, shall be liable to censure, suspension or expulsion.

Section 9. Fiscal and Administrative Year: The fiscal and administrative year of this corporation shall begin on the first day in January and end on the last day of December of the same year commencing January 1, 1971.

CHAPTER XIII
AMENDMENTS

These By-Laws may be amended or repealed by a simple majority of those Corporate Members voting in a written ballot.

Section 2. Powers of Trustees: Subject to Section 1 of this chapter, by-laws, other than a by-law or amendment thereof changing the qualifications or classes of membership, or the authorized number of Trustees, or a chaging the powers of limitations of the Board of Trustees, may be adopted, amended, or repealed by the Board of Trustees.

Filed - DEC 22, 1978
W. J. Furstenau, Clerk
U. S. District Court
For The District of Arizona

(Caption omitted in printing.)

Phoenix, Arizona
November 22, 1978
10:00 a.m.

DEPOSITION OF ANTHONY D. MITTEN

(VOL. I)

* * * *

[4]

* * * *

Q. Would you tell us your name and home address, please?

A. Anthony Mitten; 14851 North Skokie Court, Phoenix.

* * * *

Q. And with whom are you employed?

A. I am employed by the Maricopa County Medical Society

Q. What is your position with the Maricopa County Medical Society? A. Executive Director.

* * * *

[5]

* * * *

Q. Do you also hold a position with the Maricopa Foundation For Medical Care? A. Yes.

[6]

Q. What position do you hold?

A. Executive Director.

Q. With the Maricopa Foundation For Medical Care? A. Executive Director.

Q. What are your responsibilities in the Maricopa Foundation for Medical Care?

A. To administer the Foundation's operations.

Q. For what period of time have you been Executive Director for the Maricopa Foundation For Medical Care?

A. Let me explain something to you. They have changed titles. I have always been the chief administrator/officer of the Foundation since its inception, but the title of Executive Director did not exist at that time.

* * * *

[40]

Q. I see. Is it the ordinary practice of the Maricopa Foundation to execute agreements with insurance companies that underwrite Foundation plans?

A. Generally—we generally executed administrative agreements with underwriting companies.

* * * *

[56]

* * * *

Q. BY MS. METZGER: Paragraph 2 of Exhibit 17 states, "Since our agreement with the Insurance Advisory Committee indicated that whenever possible the Foundation would give 90 days notice of any changes in the minimum standards, these changes will be effective November 1, 1974, and are as follows," and certain information provided at the time Exhibit 17 was prepared and sent by you — did you have knowledge of such an agreement?

A. I believe that we have always had a similar type of agreement, yes. We are trying to notify the insurance people as much as possible in advance of any changes in the Minimum Standards,

[57]

with the hope that it would be at least 90 days.

Q. And would such notification normally be provided to the insurance companies?

A. Generally, yes.

Q. Was it then the normal practice of the Maricopa Foundation to send notices such as Exhibit 17 to members of the Insurance Advisory Committee?

* * * *

Q. BY MS. METZGER: Is it the ordinary course of business for Maricopa Foundation to send in writing notifications to members of the Insurance Advisory Committee of proposed increases in the Foundation Fee Schedule?

A. It is the normal course of business to have us advise underwriting companies of changes in the Foundation Minimum Standards.

Q. Would such changes in the Foundation Minimum Standards include changes in the Foundation reimbursement schedule?

[58]

A. Yes, it would.

* * * *

[60]

Q. Has the Martin E. Segal Company made any other actuarial determinations on the effect of certain Minimum Standards on Foundation plans on premium rates that would be charged for such plans?

A. I do believe that they have made some assumptions on that, yes.

* * * *

[63]

Q. BY MS. METZGER: Would the type of expertise sought by Exhibit 20 include a rough estimate of the effect on premiums charged for Foundation plans of the proposed increases in the Minimum Standards on Foundation plans?

A. Yes, it probably would include some assumption, or request some assumption from them.

* * * *

[64]

* * * *

Q. BY MS. METZGER: The court reporter has marked as Exhibit 22 a copy of a letter dated October 31, 1975, from yourself to Jack Donovan of

[65]

Blue Cross/Blue Shield. Would you review Exhibit 22 and tell us if that is a copy of the letter which you sent to Mr. Donvan?

A. I believe it is, yes.

Q. Was Exhibit 22 sent to Mr. Donovan at or near the date appearing thereon?

A. Yes.

Q. And was Exhibit 22 sent in the ordinary course of Maricopa Foundation's business?

A. Yes, it was.

Q. Was the same letter sent to other insurance companies at or about the date marked on Exhibit 22?

A. Not the same letter, no.

Q. Were letters containing the information concerning changes in the Foundation's Minimum Standards which is contained in Exhibit 22, sent to other insurance companies at or about that date?

A. I believe it was, yes.

[71]

* * * *

Q. BY MS. METZGER: Mr. Mitten, what relative value schedules are currently being used by the Maricopa Foundation?

A. The Foundation basically makes use of the 1964 California Relative Value Schedule and two or three other specialty schedules to determine the maximum reimbursement they make.

Q. Can you identify the two or three other specialty schedules that are used?

A. I believe the 1973 American Society of Anesthesiologists and there is the American College of Radiology, but I don't remember the year.

I think that's the only three that we use.

* * * *

[84]

* * * *

Q. BY MS. METZGER: Would it be correct to say, then, that Maricopa Foundation distributed to its members the 1964 edition of the California Relative Value Schedule, as prepared by the Maricopa Foundation, with instructions for use provided by the Maricopa Foundation?

A. We distributed it with our own cover and the instructions as indicated before.

Q. At approximately what date was that Relative Value Schedule distributed to the Foundation members by the Maricopa Foundation?

A. Well, at various dates.

Q. Could you tell me on what occasions the Relative Value Schedule has been distributed to the Foundation members by the Maricopa Foundation?

A. The main mailing would have been made, if I recall correctly, sometime in 1970. Subsequent mailings would have been made as a member joined — as a physician joined the Foundation.

* * * *

[88]

* * * *

Q. Do each of the Relative Value Schedules used by the Maricopa Foundations at the present time, assign relative value to services performed by doctors?

A. I don't think they are referred to in

[89]

that way.

Q. How would you refer to the numbers or values that are listed next to the procedures, or services identified, for example, in Exhibit 24?

MR. BERELSON: Off the record.

(Discussion off the record.)

A. I would say I believe there were two or three sets of numbers. The ones on the left-hand side of the column would be the identifying number, the number that would identify the procedure from a code standpoint.

The values on the other side, I think, in the terms are the most common understanding would be considered unit values, as opposed to relative values.

Q. BY MS. METZGER: Are those unit values used to determine the amounts payable for each of the procedures or services listed? A. In the '64?

Q. In any of the Relative Value Schedules used by the Foundation, is that the general way in which the Schedules are used?

MR. McAULIFFE: Used by whon.? Industrial Commission?

Q. BY MS. METZGER: Used by Maricopa Foundation?

[90]

A. Generally, with the exception of the amounts that might have shown the Minimum Standards, they would vary that number, that unit value.

Q. To determine the amount payable for a procedure listed in the Relative Value Schedule, the Foundation multiplies the unit value assigned to that procedure by the conversion factor adopted by the Foundation for that category of relative value; is that correct?

A. That would be the maximum allowable payment that we would make for that service, using the method you described, yes.

* * * *

[97]

* * * *

Q. BY MS. METZGER: Is Exhibit 28 currently being used by the Foundation as a Schedule of Unit Conversion Factors?

A. It currently is being used as a Conversion Factor for all groups, new or renewed groups, after December 1st, last year. There may be some groups that had different conversion factors prior to December 1st that are still in force.

* * * *

[114]

* * * *

Q. BY MS. METZGER: The court reporter has marked the letter dated September 30th which you referred to and it is attached to the Maricopa Foundation Fee Schedule ballot as Exhibit 31.

Was Exhibit 31 found in the files of the Maricopa Foundation?

A. Yes.

Q. And was Exhibit 31 within the custody, possession and control of the Maricopa Foundation prior to your producing it here this morning?

A. Yes, it was, I believe.

Q. Was Exhibit 31 kept in the course of

[115]

the Maricopa County Foundation's regular conducted business activities? A. Yes, it was.

Q. And is it the regular practice of the Maricopa Foundation to maintain such records in the course of their business activities? A. Yes.

Q. Was Exhibit 31 made at or near the date appearing thereon? A. Yes, I believe it was.

Q. Do you know what use the Maricopa Foundation made of the ballots which were sent to the members with Exhibit 31, which were returned to the Foundation by those members?

A. My recollection is that they used them to determine whether the membership would approve the change in the conversion factors.

Q. And did the membership approve the proposed change in the conversion factors?

A. My recollection is that they did.

Q. And the conversion factors approved by the Foundation are the conversion factors listed in Exhibit 21; is that correct?

* * * *

[117]

Q. BY MS. METZGER: Mr. Mitten, attached as part of Exhibit 31 is a Maricopa Foundation Fee Schedule ballot, or a document so entitled; are you

[118]

familiar with that ballot? A. Yes.

Q. Was that ballot sent in the form of a postcard to Foundation members? A. I can't answer that.

Q. I asked that because of the size of it.

A. It was on a card that may have been returned, addressed. It may have been just a postcard-size blank card that had to be sent back in an addressed envelope; I don't know.

Q. It is correct to say, however, that —

A. It is a ballot.

Q. That ballot was sent to members with the intention that the members return the ballot to the Foundation in the mail? A. Yes.

Q. Many of the members who were sent that ballot by the Foundation returned those ballots to the Foundation in the mail?

A. I can't give you specific numbers by recollection. Maybe the Minutes shows it. Yes, many, I suppose.

* * * *

Filed - DEC 22, 1978
W. J. Furstenau, Clerk
U. S. District Court
For The District of Arizona

(Caption omitted in printing.)

Phoenix, Arizona
November 22, 1978
3:10 p.m.

DEPOSITION OF ANTHONY D. MITTEN

(VOL. II)

* * * *

[6]

* * * *

Q. BY MRS. METZGER: All right. Did you have occasion to transcribe or review each of the Exhibits 32 through 45 at or about the time each of those exhibits was prepared? A. Yes.

Q. May I see those, please.

On page two of Exhibit 32, which is minutes of a July 18, 1977, meeting of the Foundation board of trustees, there is reference to returns from a questionnaire sent to Foundation members. Would Exhibit 32 then be the minutes which you referred to previously as a survey of the Foundation membership?

MR. BERELSON: Let him look at it so he can see what it is.

MRS. METZGER: Sure.

A. BY THE WITNESS: I believe these would refer to the survey that was done in the Spring of

[7]

'77.

Q. BY MRS. METZGER: Thank you. Exhibit 32, page two, further records that the board directed the staff to determine what a ten percent increase in physicians' fees would do to Foundation-endorsed insurance premiums. Did you as Executive Director of the Foundation make that determination?

MR. BERELSON: Could you let him look at that.

A. BY THE WITNESS: I believe I did. Yes.

* * * *

[18]

* * * *

Q. Yes. As of today has the Fee Reimbursement Committee submitted to the Foundation or the Foundation board of trustees a report on its evaluation of the 1974 Relative Value Schedule?

A. I think there is a preliminary report in some of those minutes somewhere, board minutes somewhere.

Q. I see. Is there any other report not found in the board minutes? A. Not that I know of.

Q. Is the Fee Reimbursement Committee then evaluating the Foundation's use of the 1974 California Relative Value Schedule rather than the 1964 California Relative Value Schedule?

A. Yeah. I believe they were appointed to look at the '74 Relative Value Schedule.

* * * *

[25]

* * * *

Q. BY MRS. METZGER: Does the Maricopa Foundation have more than one committee whose responsibilities involve a Relative Value Schedule, Schedule of Conversion Factors, or other schedule or index to prices or amounts payable? A. At the present time?

Q. Yes A. Yes. I believe it would in effect have more than one committee.

Q. I see. Would one of those committees then be the Fee Reimbursement Committee concerning which you have previously testified? A. Yes.

Q. And the responsibilities of the Fee Reimbursement Committee include the evaluation of the 1974 California Relative Value Schedule for use by the Foundation in place of the 1964 California Relative Value Schedule; is that correct?

A. I believe that was one of the charges given to the committee by the board.

[87]

* * * *

Q. BY MRS. METZGER: Exhibit 61 reports that no action can be taken since the replies from the specialty societies and other information concerning fees have not been accumulated by the Foundation. Is it the normal practice of the Foundation board of trustees not to take action concerning a Relative Value Schedule until it receives replies on that subject from specialty societies?

A. Well, the action discussed was a relation to the conversion factors that might be used for the Relative Value Schedules to determine maximum

* * * *

[88]

reimbursements.

It is usual for them to wait for information that comes from outside. In this case evidently they felt the need to. In previous cases they have done different things.

Q. At the time of the board meeting, which is recorded in Exhibit 61, which is May, 1977, the Foundation was polling specialty societies regarding relative values and conversion factors to be used by the Foundation, was it not?

A. I believe they are asking the specialty societies to give them some indication of what the usual and customary changes for certain services would be.

* * * *

Filed - APR 19, 1979
W. J. Furstenau, Clerk
U. S. District Court
For The District of Arizona

(Caption omitted in printing.)

AFFIDAVIT OF
ANTHONY D. MITTEN

STATE OF ARIZONA }
} ss.
County of Maricopa }

ANTHONY D. MITTEN, being first duly sworn, deposes and says:

1. I am Executive Director of defendant Maricopa Foundation for Medical Care ("Maricopa Foundation"). I make this affidavit to correct misstatements in Plaintiff's Reply Memorandum on the Effect of *Royal Drug* ("Plaintiff's Reply").

2. Plaintiff's assertion that "defendants' fee schedules fully protect the doctor from losing any money on a 'difficult case'" because "In addition to the values assigned for each medical procedure, the relative value schedules used by defendants provide for additional values to be added to the bill for any extra time, expense, service, materials or risk the doctor might incur on an individual patient" is not true. Participating physicians, other than anesthesiologists, are not additionally compensated for unexpected time expended or complexity encountered in performing a particular procedure on an individual patient. The relative values set forth in Exhibit E to Plaintiff's Statement of Undisputed Facts Supporting Plaintiff's Motion for Partial Summary Judgment on the Issue of Liability with Supplemental References ("Plaintiff's Statement") are based upon the time and complexity normally required for the performance of each procedure. If the cost to the physician of actual performance of a procedure exceeds its predetermined relative value, Maricopa Foundation participating physicians nevertheless agree to accept that relative value

as the basis of their maximum level of reimbursement. In cases of unusual procedures for which there is little prior experience upon which to determine a relative value, a relative value is derived by the physician's submission of a report which is subject to peer review. [Plaintiff's Statement, Ex. E, p. 9]

3. The Maricopa Foundation maximum level of compensation does not include the risk modifiers to the relative values for radiology services set forth in Exhibit F to Plaintiff's Statement on which plaintiff relies to support the foregoing incorrect assertion of fact.

4. Plaintiff's assertion that Maricopa Foundation determines anesthesiology values "by adding a 'Basic Value' which is related to the complexity of service, plus 'Modifying Units' which reflect the patient's age, physical condition and risk of complications, and 'Time Units' which reflect 'each 15 minutes or fraction thereof' the doctor spends with the patient" is not true. The method for determining the maximum level of reimbursement for anesthesiology services provided to patients insured under Maricopa Foundation-endorsed insurance programs is clearly set forth in Maricopa Foundation's Minimum Standards for Foundation-Endorsed Group Insurance Programs ("Minimum Standards"), appended as Exhibit No. MF 64 to Plaintiff's First Request for Admissions and Interrogatories.

5. The Maricopa Foundation maximum level of reimbursement for anesthesia services provided to patients insured under Maricopa Foundation-endorsed group insurance programs consists of a basic value plus time values for the time actually spent by the anesthesiologist in providing anesthesia services. Additional compensation for risk or complexity is very limited. Only "[o]*ne* risk modifier in . . . Anesthesia will be allowed for emergency cases after 6 p.m., *subject to Foundation peer review.* [Ex. No. MF 64, p. 12] (emphasis added) The Maricopa Foundation, therefore, expressly limits additional reimbursement for "risk" or

complexity to a single unit modifier for emergency cases arising after 6 p.m., and even that modification is subject to peer review of the medical necessity and appropriateness of the service provided.

6. By limiting anesthesia risk modifiers, Maricopa Foundation expressly rejected the use of risk modifiers for age and other contingencies outlined in The American Society of Anesthesiologists' Relative Value Guide 1973 ("Relative Value Guide") that is relied upon and cited by plaintiff in footnote two of Plaintiff's Reply. Maricopa Foundation participating physicians, therefore, assume the risk which would be protected against if they were reimbursed in accordance with the Relative Value Guide that plaintiff cites.

(Signature and notary clause omitted in printing.)

Filed - APR 30, 1979
W. J. Furstenau, Clerk
U. S. District Court
For The District of Arizona

IN THE UNITED STATES DISTRICT COURT FOR THE DISTRICT OF ARIZONA

STATE OF ARIZONA

Plaintiff,

vs.

MARICOPA COUNTY MEDICAL SOCIETY, an Arizona non-profit corporation; MARICOPA FOUNDATION FOR MEDICAL CARE, and Arizona non-profit corporation; PIMA COUNTY MEDICAL SOCIETY, an Arizona non-profit corporation; and PIMA FOUNDATION FOR MEDICAL CARE, an Arizona non-profit corporation,

Defendants.

NO CIV. 78-800 PHX WPC

ORDER

Pursuant to stipulation of the parties,

IT IS ORDERED that the provisions of Paragraph 6 of the Order dated November 2, 1978 in this matter shall remain in effect pending further order of this Court.

DONE IN OPEN COURT this 20 day of April, 1979.

/s/

Honorable William P. Copple
Judge, United States District Court

Filed - JUN. 15, 1979
W. J. Furstenau, Clerk
U. S. District Court
For The District of Arizona

(Caption omitted in printing.)

SEPARATE ANSWER OF MARICOPA COUNTY MEDICAL SOCIETY TO COMPLAINT

The Maricopa County Medical Society (hereinafter the "Society"), for its Answer to plaintiff's Complaint herein, admits, denies and alleges as follows:

I

No answer is made herein to the allegations set forth in paragraphs 8(b), 8(c), and 8(d) of the Complaint, as these allegations concern the status and conduct of defendants other than this answering defendant, and defendant lacks knowledge or information sufficient to form a belief concerning the truth thereof. No answer is made to the remaining allegations of the Complaint to the extent they concern or refer to the status, conduct, or activities of persons or entities other than this answering defendant.

II

Answering paragraph 1 of the Complaint, admits that the Complaint purports to allege violations of Section 1 of the Sherman Act, 15 U.S.C., § 1, but denies that that Act has been violated by this answering defendant, as alleged or at all. Further admits that the Complaint purports to invoke this Court's jurisdiction pursuant to the provisions of 28

U.S.C. § 1331 and 1337 and 15 U.S.C. § 26, but denies that this Court's jurisdiction has been properly invoked, as alleged or at all.

III

Answering paragraph 2 of the Complaint, denies that this Court has subject matter jurisdiction over the claims for relief set forth in Count One of the Complaint and, accordingly, denies that this Court may exercise pendent jurisdiction over the claims for relief set forth in Count Two of the Complaint.

IV

Answering paragraph III of the Complaint, admits only that this answering defendant is incorporated and maintains an office within the District of Arizona, that this Court has personal jurisdiction over this answering defendant, and that venue is properly laid in this judicial district, but denies the remaining allegations set forth in said paragraph.

V

Denies the truth of each and every allegation set forth in paragraph 4 of the Complaint.

VI

No answer is made to the allegations set forth in paragraph 5 of the Complaint as they are definitional in nature. This answering defendant does not thereby concede the validity or accuracy of any of the definitions set forth therein.

VII

Answering paragraph 6 of the Complaint, admits that the State of Arizona purports to bring this action on its own behalf and as *parens patriae* on behalf of the citizens of the State of Arizona, but denies that the State of Arizona has the requisite standing to maintain this action and denies that this action may be brought by the State of Arizona as *parens patriae* as alleged or at all.

VIII

Is without knowledge or information sufficient to form a belief concerning the truth of the allegations set forth in paragraph 7 of the Complaint.

IX

Admits the allegations set forth in paragraph 8(a) of the Complaint.

X

Denies the truth of the allegations set forth in paragraph 9 of the Complaint.

XI

Answering paragraphs 10 through 13 of the Complaint, inclusive, this answering defendant is without knowledge or information sufficient to form a belief concerning the truth thereof, but denies that the activities of the defendants, as alleged in the Complaint, occurred in interstate commerce or had a direct and substantial effect upon such interstate commerce, as alleged or at all, and denies that this Court has subject matter jurisdiction over the claims for relief set forth in the Complaint.

XII

Denies the truth of each and every allegation set forth in paragraph 14 of the Complaint.

XIII

Denies the truth of each and every allegation set forth in paragraph 15 of the Complaint, and each of its subparagraphs.

XIV

Denies the truth of each and every allegation set forth in paragraph 16 of the Complaint, and each of its subparagraphs.

XV

Denies the truth of each and every allegation set forth in paragraph 17 of the Complaint, and each of its subparagraphs.

XVI

Answering paragraph 18 of the Complaint, this answering defendant repeats and realleges the allegations contained in the foregoing paragraphs of this Answer as if fully set forth herein.

XVII

Denies the truth of each and every allegation set forth in paragraph 19 of the Complaint.

XVIII

The Complaint, and each Count thereof, fail to state a claim upon which relief can be granted against this answering defendant.

XIX

This Court lacks subject matter jurisdiction over the claims for relief set forth in the Complaint, and each Count thereof.

XX

The claims for relief set forth in the Complaint, and each Count thereof, concern activities which constitute the "business of insurance" within the meaning of the McCarran-Ferguson act, 15 U.S.C. § 1011, *et seq.*, and are thus exempt from the antitrust laws.

XXI

Each allegation of the Complaint not expressly herein admitted is expressly denied.

WHEREFORE, having fully answered, defendant Maricopa County Medical Society prays that plaintiff's Complaint be dismissed and that plaintiff take nothing thereby, that defendant be awarded its costs herein incurred, and for such other and further relief as may seem just in the premises.

DATED this 15th day of June, 1979.

(Signature omitted in printing.)

Filed - JUN 15, 1979
W. J. Furstenau, Clerk
U. S. District Court
For The District of Arizona

ANSWER OF DEFENDANT MARICOPA FOUNDATION FOR MEDICAL CARE

Defendant Maricopa Foundation for Medical Care ("Maricopa Foundation"), by its undersigned attorneys, answers the complaint herein as follows:

1. Denies each and every averment of paragraph 1 except admits that plaintiff purports to bring this action and to invoke the jurisdiction of this Court pursuant to the statutory provisions cited therein.

2. Denies each and very averment of paragraphs 2, 4, 9, 14, 15 and each subparagraph thereof, 16 and each subparagraph thereof, 17 and each subparagraph thereof, and 19.

3. Denies each and every averment of paragraph 3, except states that it is without knowledge or information sufficient to form a belief as to the truth of the averments with respect to defendants Pima County Medical Society ("Pima

Society") and Pima Foundation for Medical Care ("Pima Foundation"), admits that plaintiff purports to lay venue in this District pursuant to the statutory provisions cited therein and that Maricopa Foundation and Maricopa County Medical Society ("Maricopa Society") are each incorporated, each maintains an office, and each transacts business within the District of Arizona.

4. Admits that plaintiff purports to define the terms set forth in subparagraphs (a)-(i) of paragraph 5 for use in the complaint, states that it is without knowledge or information sufficient to form a belief as to the truth of the averments contained therein and denies that the terms have been defined in accordance with commonly accepted usage.

5. Denies the averments of paragraph 6 except admits that plaintiff purports to bring this action on its own behalf and as *parens patriae* on behalf of the citizens of the State of Arizona.

6. States that it is without knowledge or information sufficient to form a belief as to the truth of the averments of paragraph 7 except denies that plaintiff and citizens of Arizona have been and continue to be injured by the violations of the antitrust laws alleged in the complaint.

7. States that it is without knowledge or information sufficient to form a belief as to the truth of the averments contained in subparagraphs (c) and (d) of paragraph 8 and denies each and every averment contained in subparagraph (b) of paragraph 8 except admits that it is an Arizona nonprofit corporation with its principal place of business in Phoenix, Arizona, that it has four classes of membership, that the Executive Director of the Maricopa Society is also its Executive Director, and states that every person, upon becoming a member of the Board of Directors of the Maricopa Society is entitled to become, and, without further action or proceeding, becomes an administrative member of it, and states that it is without knowledge or information sufficient to form a belief as to the truth of the averment

that over 70 percent of the doctors practicing in Maricopa County are participating or cooperating members of the Maricopa Foundation.

8. States that it is without knowledge or information sufficient to form a belief as to the truth of the averments contained in paragraph 10.

9. States that it is without knowledge or information sufficient to form a belief as to the truth of the averments contained in paragraph 11 except denies that doctors in Arizona prescribe medicines and other goods and products which are shipped in interstate commerce and form an integral part of the interstate distribution of such prescription drugs, goods and products and that the practice of medicine involves the purchase, use and sale of goods and products which are manufactured and sold and flow in a continuous and uninterrupted stream of interstate commerce.

10. States that it is without knowledge or information sufficient to form a belief as to the truth of the averments of paragraph 12 except denies that health insurance involves a continuous and uninterrupted flow of services, products, contracts and claims in interstate commerce.

11. Denies each and every averment of paragraph 13 with respect to it except admits it endorses health insurance plans and it will not endorse a health insurance plan unless it meets minimum standards for Foundation-endorsed group insurance programs formulated by it or it agrees in writing to a modification of those standards, and that some plans endorsed by it are underwritten by private insurers, each such private insurer doing business from a location in Arizona and at least some doing business from locations outside Arizona and states that it is without knowledge or information sufficient to form a belief as to the truth of the averments contained in paragraph 13 with respect to the Pima Foundation.

12. Maricopa Foundation repeats and realleges its answers to paragraphs 1 through 17 of the complaint in the same manner and to the same extent as though each answer were again set forth in full.

FIRST AFFIRMATIVE DEFENSE

13. The complaint fails to state a claim against Maricopa Foundation upon which relief can be granted against it.

SECOND AFFIRMATIVE DEFENSE

14. The Court lacks jurisdiction over the subject matter alleged in the complaint.

THIRD AFFIRMATIVE DEFENSE

15. The claims set forth in the complaint are barred by the doctrine of unclean hands.

FOURTH AFFIRMATIVE DEFENSE

16. The claims set forth in the complaint are barred by plaintiff's wilful failure to comply with the requirements of A.R.S. §§ 44-1401 *et seq.*

FIFTH AFFIRMATIVE DEFENSE

17. The claims set forth in the complaint are barred by the doctrine of laches.

SIXTH AFFIRMATIVE DEFENSE

18. Plaintiff is estopped from pursuing the claims set forth in the complaint.

SEVENTH AFFIRMATIVE DEFENSE

19. The claims set forth in the complaint concern activities which constitute the business of insurance which is exempt from the antitrust laws pursuant to the McCarran-Ferguson Act, 15 U.S.C. § 1011 *et seq.*

WHEREFORE, Maricopa Foundation demands judgment dismissing the complaint with prejudice, together with its costs and disbursements incurred herein and for such other and further relief as is appropriate.

June 18, 1979.

(Signature omitted in printing.)

Filed - JUN 27, 1979
W. J. Furstenau, Clerk
U. S. District Court
For The District of Arizona

(Caption omitted in printing.)

MOTION OF DEFENDANT MARICOPA FOUNDATION FOR MEDICAL CARE TO VACATE TEMPORARY RESTRAINING ORDER OF APRIL 30, 1979 AND NOTICE OF SUBMISSION WITHOUT A HEARING

Defendant Maricopa Foundation for Medical Care ("Maricopa Foundation") moves the Court, pursuant to Rule 65(b) of the Federal Rules of Civil Procedure, to vacate its Order entered April 30, 1979 extending indefinitely the effectiveness of the temporary restraining order contained in Paragraph 6 of the Order dated November 2, 1978 on the grounds that: (1) Maricopa Foundation only stipulated to extend that temporary restraining order for three weeks beyond the Court's determination of the motions decided by the Court on June 5, 1979; (2) Maricopa Foundation will be severely prejudiced by the continuation of that order; (3) plaintiff has not carried its burden of showing the threat of irreparable injury to justify the issuance of a preliminary injunction; (4) plaintiff has not carried its burden of demonstrating probability of success on the merits, and; (5) plaintiff has failed to give security, all of which more fully appear in the accompanying memorandum submitted in support of this motion. Alternatively, Maricopa Foundation moves that plaintiff be required to give security pursuant to Rule 65(c) of the Federal Rules of Civil Procedure.

Please take notice that this motion is submitted pursuant to Local Rule 11(f) without a hearing.

(Signatures omitted in printing.)

File - JUN 27, 1979
W. J. Furstenau, Clerk
U. S. District Court
For The District of Arizona

(Caption omitted in printing.)

MEMORANDUM IN SUPPORT OF DEFENDANT MARICOPA FOUNDATION FOR MEDICAL CARE'S MOTION TO VACATE TEMPORARY RESTRAINING ORDER OF APRIL 30, 1979

PRELIMINARY STATEMENT

On April 30, 1979, this Court extended indefinitely the temporary restraining order contained in Paragraph 6 of its Order dated November 2, 1978.* Defendant Maricopa Foundation for Medical Care ("Maricopa Foundation") now moves the Court to vacate that order pursuant to Rule 65(b) of the Federal Rules of Civil Procedure on the grounds that: (1) Maricopa Foundation has not stipulated to any extension of the temporary restraining order beyond June 26, 1979; (2) Maricopa Foundation will be severely prejudiced by the continuation of that order; (3) plaintiff has not carried its burden of showing irreparable injury necessary to justify a continuation of the restraint; (4) plaintiff has not carried its burden of demonstrating probability of success on the merits, and; (5) plaintiff has failed to give security as required by Fed. R. Civ. P. 65(c). To permit Paragraph 6 of the November 2 Order to remain in

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*Paragraph 6 provides:

For the purpose of maintaining the status quo until plaintiff's preliminary injunction motion may be heard, until the earlier of May 1, 1979, or final judgment for any party in this action, or further order of this Court, no defendant, nor any officer, agent, servant, employee or attorney of any defendant nor any person in active concert or participation with any defendant who receives actual notice of this order by personal service or otherwise shall participate in any survey, agreement, vote or other step to establish, determine or disseminate any relative value or conversion factor with respect to medical services, goods or products other than those relative values and conversion factors in effect on or before October 18, 1978.

effect constitutes the *de facto* issuance of a preliminary injunction without plaintiff having made the required showing of entitlement to such relief pursuant to Rule 65(a).

ARGUMENT

THE COURT'S NOVEMBER 2, 1978 TEMPORARY RESTRAINING ORDER CANNOT BE CONVERTED INTO A PRELIMINARY INJUNCTION WITHOUT ANY SHOWING BY PLAINTIFF OF ENTITLEMENT TO SUCH EXTRAORDINARY RELIEF.

1. Because Maricopa Foundation Never Stipulated to an Extension of the Temporary Restraining Order Beyond June 26, 1979, Plaintiff Cannot Simply Treat the Order as an Open-Ended Preliminary Injunction.

In its Motion for Extension of Temporary Restraining Order filed on April 20, 1979, plaintiff represented to the Court that the parties had been unable to agree upon a stipulated extension of the temporary restraining order which by its terms expired May 1, 1979. In fact, defendants had offered to stipulate to an extension of Paragraph 6 of the November 2 Order for three weeks after the Court's decision if the Court denied the then pending motions to dismiss. (Maricopa Foundation For Medical Care's Response to Plaintiff's Motion for Extension of Temporary Restraining Order, at 2 (April 25, 1979).) Not content with anything short of open-ended injunctive relief, this offer was rejected by plaintiff.

Apparently realizing that the April 30 Order gives it the equivalent of a preliminary injunction, plaintiff no longer presses for a hearing on its pending application for an order to show cause. At the Rule 42A conference held on Thursday, June 21, 1979, plaintiff's counsel represented that plaintiff intended to move for reconsideration of this Court's June 5, 1979 Order, or in the alternative, certification of that ruling pursuant to 28 U.S.C.A. § 1292(b), or alternatively for summary judgment under the rule-of-

reason standard applicable to the practices challenged in this case. Although declining to stipulate to a vacation of the April 30 Order, plaintiff did not disclose any intention to move forward with a hearing on its motion for a preliminary injunction.* Furthermore, any preliminary injunction hearing would necessarily be delayed because plaintiff has yet to respond fully to defendant's outstanding discovery requests and to date has not even stated when its responses will be forthcoming.

Under the circumstances, plaintiff has simply ignored *its* burden of showing entitlement to a preliminary injunction, choosing instead to treat the order as having already issued. Rule 65(b), however, prohibits any such effect being attributed to the extension of the temporary restraining order absent the consent of the Maricopa Foundation. And the Maricopa Foundation has *not* consented to any such extension.

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* Plaintiff cannot have it both ways. It is well-established that an order extending a TRO beyond the time limits permitted by Fed. R. Civ. P. 65(b) is treated like a preliminary injunction, *National City Bank v. Battisti*, 581 F.2d 565, 568 (6th Cir. 1977) ("Upon examination of the entire record this court concludes that the motion of the various parties . . . for extension of the injunctive provisions of the November 4th order should be treated as a motion for a preliminary injunction, and the November 18th order of the district court was in effect a preliminary injunction which was intended to extend and enlarge the injunctive provisions of the temporary restraining order of November 4th and was intended to make the injunctive provisions effective beyond the time permitted under a temporary restraining order by Rule 65(b)"); therefore, without a hearing, the issuance of findings of fact and conclusion of law and the giving of security, the validity of the order is questionable. *Granny Goose Foods, Inc. v. Brotherhood of Teams, Etc.*, 415 U.S. 423, 443 n.17 (1974) ("Where a temporary restraining order has been continued beyond the time limits permitted under Rule 65(b), and where the required findings of fact and conclusions of law have not been set forth, the order is invalid").

2. The Harm to Maricopa Foundation and the Absence of Any Showing of Irreparable Injury to Plaintiff Are Sufficient Grounds to Vacate the Temporary Restraining Order.

The provisions of Paragraph 6 of the November 2 Order, as continued in effect by the Court's April 30 Order, prohibit the Maricopa Foundation from taking any steps to alter the maximum level of reimbursement payable to physicians for services rendered to patients insured under Foundation-endorsed health insurance plans. Defendant has not adjusted its maximum level of reimbursement since December 1, 1977. (Affidavit of Anthony D. Mitten, para. 3, annexed hereto as Exhibit "A".) During this period, increasing costs to participating physicians have rendered it uneconomical for them to continue to provide services to subscribers of Foundation-endorsed plans at the current maximum levels of reimbursement; in fact, many physicians have expressed an unwillingness to continue their participation absent a revision in the maximum level of reimbursement.* (*Id.*, para. 4.) As a result, the viability of the Foundation is threatened by its inability to offer fair and reasonable reimbursement to the providers of services to Foundation-plan subscribers. Additionally, the Foundation cannot negotiate renewal of outstanding agreements due to expire with the underwriters of its plans or with existing groups when there is a serious question concerning continued physician participation. (*Id.*, para. 5.) This threat to defendant's economic viability by itself is sufficient grounds to vacate the continuing restraint on the Maricopa Foundation. *Democratic Cent. Com. of D.C. v. Washington Met. A.T. Com'n*, 436 F.2d 233, 235 (D.C. Cir. 1970)

* It cannot be doubted that *if* physicians resign due to the prevailing low reimbursement levels applicable to Foundation-endorsed plans, the cost of medical care to those otherwise covered by Foundation-endorsed plans will necessarily increase when the constraint of Foundation reimbursement levels is removed. It follows that the public interest is not served by an order that in effect forces the public to pay *more* for health care.

(declining to stay an order authorizing a fare increase by the D.C. Transit System, Inc., the court stated that "[w]e, however, cannot ignore the prospect, to which the record lends credence, that the increases are essential to Transit's continued existence, nor can we treat lightly the serious constitutional question that denial of the increases would pose in the circumstances").

In contrast to the obvious harm to Maricopa Foundation from the continuation of the temporary restraining order, plaintiff has not and cannot show the threat of irreparable injury necessary to warrant the issuance of a preliminary injunction. The *only* injuries alleged by plaintiff in Paragraph VIII of the Complaint are higher prices which, if shown, might conceivably be compensable by money damages. By definition, such alleged injury is not irreparable and thus not a sufficient basis for the award of temporary or preliminary injunctive relief even where plaintiff alleges the amount of damage is substantial.* *SCM Corp. v. Xerox Corp.*, 507 F.2d 358, 360, 363 (2d Cir. 1974) (affirming denial of preliminary injunction because plaintiff had not shown irreparable injury where it claimed damages of threefold the amount of $145,000,000, court stated that plaintiff "admittedly cannot escape its burden of establishing the threat of irreparable harm. The statute [Section 16 of the Clayton Act] so requires and we are not free to disregard it. Indeed, the flaw in the SCM case here is its continuing failure to supply proof of a threat of irreparable

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* Plaintiff asserted in support of its application to require defendants to post a bond that a continuation of the subject practices would result in substantial damages to the citizens of Arizona. (Memorandum in Support of Motion to Vacate or Modify Stay Order of December 27, 1978, at 17-18 (January 12, 1979).) Accepting arguendo the grossly inflated figures put forth by plaintiff, still the only "damage" claimed by plaintiff is calculable and compensable. It should be noted that on a per capita basis the figure is *de minimis*. Moreover, even were the prospect of future money damages a form of irreparable harm, any increase in maximum levels of reimbursement would not be effective until January 1, 1980, undermining any claims by plaintiff that relief *pendente lite* is necessary (Affidavit of Anthony D. Mitten, para. 5).

harm. [I]t is basic that equitable relief will not be granted where an adequate remedy at law exists. Money damages . . . constitute such an adequate remedy").

To summarize, plaintiff cannot make out the indispensible predicate to injunctive relief—irreparable harm. On the other hand, Maricopa Foundation is directly and seriously prejudiced by the temporary restraining order not only in terms of immediate financial loss but in terms of a real threat to its continued existence. The harm to defendant from contination of the temporary restraining order surely outweighs any alleged but unproved irreparable injury to plaintiff.

3. Because Maricopa Foundation's Conduct Is to Be Tested Under the Rule of Reason, Plaintiff Has Not Demonstrated Likelihood of Success on the Merits.

Equally fatal to any effort by plaintiff to secure a *de facto* preliminary injunction through extension of the November 2 Temporary Restraining Order is its inability to show a reasonable likelihood of success on the merits. In its Order of June 5, 1979, denying plaintiff's motion for summary judgment, this Court concluded that "the Rule of Reason approach should be used in analyzing the challenged conduct in the instant case." (Memorandum and Order at 12.) The Court further stated that plaintiff would be required to present sufficient evidence "as to the purpose and effect of the allegedly unlawful practices and the power of the defendant." *Id.*

As a result of the Court's ruling, the predicate underlying plaintiff's motion for a preliminary injunction has vanished. In support of its motion, plaintiff argues that the "clarity of this *per se* rule" demonstrates the "strong probability that plaintiff will succeed in the merits." (Memorandum in Support of Order to Show Cause and Motion for Preliminary

Injunction, at 12 (Oct. 25, 1978).) The factual inquiries now mandated under the Court's ruling eliminate plaintiff's simplistic assessment of the ultimate outcome of the litigation.

Antitrust cases involving conduct tested by the Rule of Reason are particularly unsuited to the issuance of temporary or preliminary injunctive relief restraining the challenged practice. *Fuchs Sugar & Syrups, Inc. v. Amstar Corporation*, 380 F. Supp. 441, 444 (S.D.N.Y. 1974) (denying motion for preliminary injunction, the court stated "[T]he Court is not convinced that Amstar's actions constitute a scheme to fix prices, which would be *per se* illegal, but rather sees numerous factual and legal questions.... It does not yet clearly appear to this Court that defendant has acted with the purpose or the effect of reducing competition or unlawfully extending a monopoly position in the market"); *see Heldman v. United States Lawn Tennis Ass'n*, 354 F. Supp. 1241, 1250 (S.D.N.Y. 1973) (no reasonable probability of ultimate success where "there are close and complex issues raised—particularly with regard to the antitrust allegations—which should only be resolved upon a full trial of the facts"); *Jones v. National Collegiate Athletic Ass'n*, 392 F. Supp. 295, 304 (D.Mass. 1975) (court found no substantial likelihood of success to warrant preliminary injunctive relief, stating: "In order to make out a group boycott claim the plaintiff must allege that the defendant's purpose was to exclude a person or group from the market or accomplish some other anticompetitive objective. The issue in group boycott cases then is not merely the existence or nonexistence of a concerted refusal to deal, but rather whether the association was designed to exclude outsiders from participation in the marketplace"). Because the Court has now determined that the Rule of Reason test will be applied in this case, it would simply be an exercise in conjecture for plaintiff to contend that it will ultimately prevail on the merits before the facts have been fully developed. Application of the Rule of Reason gives rise to complex issues whose resolution is most

appropriately left for trial. In advance of trial, no informed and reasoned showing can be made by plaintiff that a determination of these issues will be in its favor. The Order of April 30, 1979 should therefore be vacated.

4. If the Order of April 30, 1979 Is Not Vacated, Its Continuation Should Be Conditioned Upon Plaintiff's Giving Security as Required Under the Federal Rules of Civil Procedure.

While plaintiff has repeatedly characterized Paragraph 6 of the November 2 Order as injunctive relief,* it has conveniently ignored Fed. R. Civ. P. 65(c) which requires a party obtaining a temporary restraining order or preliminary injunction to give security in the event that the restrained party is found to have been wrongfully enjoined. Rule 65(c) is, by its terms, mandatory, declaring in pertinent part:

> *No* restraining order or preliminary injunction *shall issue* except upon the giving of security by the applicant, in such sum as the court deems proper, for the payment of such costs and damages as may be incurred or suffered by any party who is found to have been wrongfully enjoined or restrained.* (Emphasis added.)

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*See, *e.g.*, Memorandum in Support of Motion to Vacate or Modify Stay Order of December 27, 1978, at 17 (Jan. 12, 1979) ("The stay order should certainly be clarified to preserve the prohibitory injunction of Paragraph 6 of the November 2, 1978 Order").

*C. Wright & A. Miller, *Federal Practice and Procedure* § 2954, at 524:

> Although it is settled that security need not be posted at the time interlocutory injunctive relief is applied for, the rule is phrased in mandatory terms and the conclusion seems inescapable that once the court decides to grant equitable relief under Rule 65 it must require security from the applicant. In fact, a district court's failure to require the posting of a bond or other security has been held reversible error.

Section 16 of the Clayton Act, 15 U.S.C.A. § 26, similarly provides that an injunction shall not issue except "upon the execution of proper bond against damages for an injunction improvidently granted."

The Court does, of course, have discretion with respect to the *amount* of the security that will be required. In this regard, "the judge usually will fix security in an amount that covers the potential incidental and consequential costs and ... the losses the unjustly enjoined or restrained party will suffer during the period he is prohibited from engaging in certain activities. ..." C. Wright & A. Miller *Federal Practice and Procedure* § 2954, at 525. Plaintiff has itself furnished to the Court its calculation of the amount of the loss which defendant will suffer by virtue of continuing the temporary restraining order. In its Motion to Vacate or Modify Stay Order of December 27, 1978, at 17 (Jan. 12, 1979), plaintiff calculates those losses at $1.8 million per month. Therefore, if the Court does not vacate the temporary restraining order, Maricopa Foundation submits that plaintiff should be required to post a bond in favor of Maricopa Foundation sufficient to cover the losses accruing to Maricopa Foundation at the rate of $1.8 million per month for so long as the Court permits a temporary restraining order or preliminary injunction to remain in effect.

Conclusion

For the foregoing reasons, defendant Maricopa Foundation submits that the Court's Order of April 30, 1979 should be vacated or, in the alternative, that plaintiff should be required to give security in an amount to be determined by the Court but not less than $1.8 million per month for so long as the Court permits a restraining order or preliminary injunction to remain in effect.

(Signature omitted in printing.)

(Caption omitted in printing.)

AFFIDAVIT OF ANTHONY D. MITTEN

STATE OF ARIZONA }
} ss.
County of Maricopa }

Anthony D. Mitten, being first duly sworn, under oath, deposes and say:

1. I am the Executive Director of defendant Maricopa Foundation for Medical Care ("Maricopa Foundation"). I make this affidavit in support of Maricopa Foundation's Motion to Vacate the Temporary Restraining Order of April 30, 1979.

2. On or about November 2, 1978, Maricopa Foundation stipulated to the entering of an order whereby it agreed to refrain until no later than May 1, 1979 from "participat[ing] in any survey, agreement, vote or other step to establish, determine or disseminate any relative value or conversion factor with respect to medical services, goods or products other than those relative values and converison factors in effect on or before October 18, 1978." [Stipulation dated November 2, 1978, para. 6] Prior to the filing of Plaintiff's Motion for Extension of Temporary Restraining Order on April 20, 1979, Maricopa Foundation offered to stipulate to extend that order three weeks beyond determination of the Rule 12 motions then pending. The stipulation of November 2, 1978 and offer to extend the stipulation in April 1979 were made in good faith and were based upon Maricopa Foundation's best judgment as to the length of time during which it could agree to maintain the status quo without jeopardizing its economic viability and, hence, its ability to serve as a competitive alternative in the providing of health care services in Maricopa County, Arizona.

3. Maricopa Foundation presently compensates physicians who provide services to patients insured under Marico, Foundation endorsed insurance programs in accordance with a maximum level of reimbursement that was effective as of December 1, 1977. Maximum levels or reimbursement to Maricopa Foundation members for treating patients insured under Maricopa Foundation endorsed health insurance plans have remained the same for a period of nearly two years, despite the high general rate of inflation in the national economy.

4. Increasing numbers of Maricopa Foundation members have requested that they be allowed to terminate their memberships because the Maricopa Foundation's current maximum levels of reimbursement in many cases do not adequately compensate physicians for the services they provide.

5. In order for Maricopa Foundation to maintain its membership and to continue to provide a competitive health care alternative, it is imperative that it be permtted to establish new maximum levels of reimbursement (to be effective no sooner than January 1, 1980) upon which to base negotiations for the renewal of outstanding agreements with employee groups and underwriters which shall expire on or before December 31, 1979. If the Maricopa Foundation is not permitted to negotiate contracts on the basis of new maximum levels of reimbursement, its economic viability will be seriously threatened and it will be irreparably damaged.

(Signature and notary clause omitted in printing.)

Filed - JUN 29, 1979
W. J. Furstenau, Clerk
U. S. District Court
For The District of Arizona

(Caption omitted in printing.)

MOTION OF DEFENDANT PIMA FOUNDATION FOR MEDICAL CARE TO VACATE TEMPORARY RESTRAINING ORDER OF APRIL 30, 1979, AND NOTICE OF SUBMISSION WITHOUT A HEARING

The defendant, Pima Foundation for Medical Care (Pima Foundation), appears and joins with the Maricopa Foundation for Medical Care in that defendant's Motion to vacate the Court's Order of April 30, 1979, on the grounds and for the reasons set forth in the moving papers of the defendant, Maricopa Foundation, and the affidavit of Thomas P. Finley, the Executive Director of the Pima Foundation for Medical Care, attached hereto and made a part hereof.

This motion is also submitted pursuant to Local Rule 11(f) without a hearing.

(Signature omitted in printing.)

(Caption omitted in printing.)

AFFIDAVIT OF THOMAS P. FINLEY

STATE OF ARIZONA }
} ss.
County of Pima }

Thomas P. Finley, being first duly sworn, under oath, deposes and says:

1. That I am the Executive Director of Defendant Pima Foundation for Medical Care (Pima Foundation). I make this affidavit in support of Pima Foundation's Motion to Vacate the Temporary Restraining Order of April 30, 1979.

2. On or about November 2, 1978, Pima Foundation stipulated to the entering of an order whereby it agreed to refrain until no later than May 1, 1979, from "participat[ing] in any survey, agreement, vote or other step to establish, determine or disseminate any relative value or conversion factor with respect to medical services, goods or products other than those relative values and conversion factors in effect on or before October 18, 1978." (Stipulation dated November 2, 1978, para. 6). Prior to the filing of Plaintiff's Motion for Extension of Temporary Restraining Order on April 20, 1979, Pima Foundation offered to stipulate to extend that order three weeks beyond determination of the Rule 12 motions then pending. The stipulation of November 2, 1978, and offer to extend the stipulation in April, 1979, were made in good faith and were based upon Pima Foundation's best judgment as to the length of time during which it could agree to maintain the status quo without jeopardizing its economic viability and, hence, its ability to serve as a competitive alternative in the providing of health care services in Pima County, Arizona.

3. Pima Foundation presently compensates physicians who provide services to patients insured under Pima Foundation endorsed insurance programs in accordance with a maximum level of reimbursement that was effective as of December 1, 1977. Maximum levels of reimbursement to

Pima Foundation members for treating patients insured under Pima Foundation endorsed health insurance plans have remained the same for a period of nearly two years, despite the high general rate of inflation in the national economy.

4. Increasing numbers of Pima Foundation members have requested that they be allowed to terminate their memberships because the Pima Foundation's current maximum levels of reimbursement in many cases do not adequately compensate physicians for the services they provide.

5. In order for Pima Foundation to maintain its membership and to continue to provide a competitive health care alternative, it is imperative that it be permitted to establish new maximum levels of reimbursement (to be effective no sooner than January 1, 1980) upon which to base negotiations for the renewal of outstanding agreements with employee groups and underwriters which shall expire on or before December 31, 1979. If the Pima Foundation is not permitted to negotiate contracts on the basis of new maximum levels of reimbursement, its economic viability will be seriously threatened and it will be irreparably damaged.

(Signature and notary clause omitted in printing)

Filed - JUL 11, 1979
W. J. Furstenau, Clerk
U. S. District Court
For The District of Arizona

(Caption omitted in printing.)

NO. CIV. 78-800 PHX-WPC
MEMORANDUM AND ORDER

Defendants Maricopa Foundation for Medical Care and Pima Foundation for Medical Care have moved to vacate the order of the Court dated April 30, 1979, which continued until further order the temporary restraining order contained in Paragraph 6 of the order dated November 2, 1978. The defendants have established irreparable injury to themselves by substantiating without dispute through affidavits that participating physicians have threatened to withdraw from the defendant foundations. The plaintiff, on the other hand, has failed to show injury to itself and those it represents that cannot be compensated by money damages or that could be avoided if the motion to vacate the temporary restraining order were denied. The plaintiff has also not demonstrated that the injury to it in granting the motion exceeds that incurred by defendants in denying the motion. The plaintiff, moreover, has not shown that it is likely to succeed on the merits based on the Rule-of-Reason approach adopted here, which requires relatively complex factual inquiries. Thus, whether treated as a motion to va-

cate the temporary restraining order, or, because of the lapse of time and the preparation of the parties, as an application for a preliminary injunction, the defendants are entitled to relief. Therefore,

IT IS ORDERED:

The defendants' motion to vacate the April 30, 1979, temporary restraining order is granted.

DATED July 17, 1979.

/s/
United States District Judge

Filed - JUL 6, 1979
W. J. Furstenau, Clerk
U. S. District Court
For The District of Arizona

(Caption omitted in printing.)

PLAINTIFF'S MOTION FOR SUMMARY JUDGMENT AND PERMANENT INJUNCTION

Plaintiff STATE OF ARIZONA moves pursuant to Rule 56(a), Federal Rules of Civil Procedure, for entry of an order awarding summary judgment in its favor and against defendants that defendants' combination and conspiracy and acts done in pursuance thereof were and are an unreasonable restraint of trade and commerce in violation of section 1 of the Sherman Act, 15 U.S.C. § 1, and the Uniform State Antitrust Act, Ariz. Rev. Stat. Ann. § 44-1402, under the Rule of Reason standard, and permanently enjoining defendants and their members from continuing those activities and from entering into any combination, conspiracy, agreement, understanding or concert of action having a similar purpose or effect.

In the event summary judgment is not rendered fully on this motion as prayed, plaintiff respectfully requests in the alternative that the Court enter an order pursuant to Rule 56(d), Federal Rules of Civil Procedure, specifying the facts that appear without substantial controversy and the issues of fact and law that remain to be tried and directing further proceedings in this matter including the hearing of plaintiff's motion for preliminary injunction.

This motion is based upon section 1 of the Sherman Act, 15 U.S.C. § 1, section 16 of the Clayton Act, 15 U.S.C. § 26, the Uniform State Antitrust Act, Ariz. Rev. Stat. Ann. §§ 44-1402, 44-1408, Rule 56, Federal Rules of Civil Procedure, the entire record in this matter and the accompanying statement of undisputed facts and memorandum of law.

DATED: July 6, 1979.

(Signature omitted in printing.)

Filed - JUL 6, 1979
W. J. Furstenau, Clerk
U. S. District Court
For The District of Arizona

(Caption omitted in printing.)

MEMORANDUM IN SUPPORT OF PLAINTIFF'S MOTION FOR SUMMARY JUDGMENT AND PERMANENT INJUNCTION

I.
INTRODUCTION

Plaintiff State of Arizona previously moved on November 20, 1978 for partial summary judgment on the issue of liability in this matter, basing its legal argument primarily upon the *per se* standard of liability. Having determined that the Rule of Reason approach should be used in analyzing the conduct at issue in this case, this Court denied plaintiff's motion of November 20, 1978, with leave to file a similar motion based upon the Rule of Reason standard (Memorandum and Order of June 5, 1979).[1] Plaintiff readily accepts that invitation and respectfully requests that the Court enter its order granting summary

[1] Plaintiff has respectfully requested in a separate motion filed concurrently with this motion for summary judgment and permanent injunction that this Court reconsider and vacate its Memorandum and Order of June 5, 1979, insofar as it denied plaintiff's motion for partial summary judgment on the issue of liability based upon the conclusion that the *per se* standard of analysis does not apply to price-fixing by a professional trade association, and that it grant plaintiff's motion for partial summary judgment on the issue of liability. Alternatively, that motion requests this Court to enter its order pursuant to 28 U.S.C. § 1292(b) that insofar as it denied plaintiff's motion for partial summary judgment on the issue of liability the Memorandum and Order of June 5, 1979 involves a controlling question of law as to which there is substantial ground for difference of opinion and that an immediate appeal from that portion of the order may materially advance the ultimate termination of the litigation. Plaintiff's Motion for Reconsideration of Memorandum and Order of June 5, 1979, or alternatively, Motion for Certification for Interlocutory Appeal Pursuant to 28 U.S.C. § 1292(b) of Memorandum and Order of June 5, 1979.

judgment in plaintiff's favor and against defendants that the conduct of defendants alleged by plaintiff and established by the record in this case is in violation of section 1 of the Sherman Act and Arizona's Uniform State Antitrust Act under the Rule of Reason standard, and providing permanent injunctive relief from the continuation of such conduct. In the alternative plaintiff respectfully requests that the Court make an order pursuant to Rule 56(d), Federal Rules of Civil Procedure, specifying the facts that appear without substantial controversy and the issues of fact and law that remain to be tried, and directing further proceedings in this matter including the hearing of plaintiff's motion for preliminary injunction.

"The inquiry mandated by the Rule of Reason is whether the challenged agreement is one that promotes competition or one that suppresses competition." *National Society of Professional Engineers v. United States*, 435 U.S. 679, 691, 98 S. Ct. 1355, 1365 (1978). In this case, the undisputed evidence establishes that the defendant foundations function as doctors' cartels whose members adopt by majority vote the prices they will accept for services rendered to individual patients on a fee-for-service basis. It is undisputed that the price-fixing activities at issue here are entirely horizontal in nature, as the agreed-upon price increases and uniform fee schedules adopted by the defendants are determined by a majority vote of defendants' doctor members not the insurers and other third parties that pay for doctors' services in accordance with the foundation fee schedules.

That the horizontal price-fixing activities of these doctors' cartels has been patently anticompetitive both in purpose and effect is amply documented in the record. Whatever procompetitive benefits the defendants might assert could be achieved by far less anticompetitive procedures than those at issue here. *See Smith v. Pro Football, Inc.*, 593 F.2d 1173, 1183-1189 (D.C. Cir. 1978); *Mackey v. National Football League*, 543 F.2 606, 620-622 (1976).

Because the undisputed facts in this matter reveal that defendants' price-fixing activities have been far more restrictive than necessary to serve any legitimate purpose, summary judgment is appropriate under the Rule of Reason standard. *E.g., Associated Press v. United States*, 326 U.S. 1, 65 S. Ct. 1416 (1945); *Kapp v. National Football League*, 390 F. Supp. 73, 82-83 (N.D. Cal. 1974), *aff'd*, 586 F.2d 644 (9th Cir. 1978); *see National Society of Professional Engineers*, 435 U.S. at 691-92, 98 S. Ct. at 1365-66; *Silver v. New York Stock Exchange*, 373 U.S. 341, 345, 360-61, 83 S.Ct. 1246, 1251, 1259 (1963).

II.

SUMMARY OF THE FACTS[2]

A. The Defendants

It is undisputed that each of the defendants is an association of doctors[3] who are licensed to practice in the State of Arizona (Statement of Undisputed Facts Supporting Plaintiff's Motion for Summary Judgment and Permanent Injunction (hereinafter "Statement of Facts" No. 1). The defendant medical societies are the local components of the American Medical Association in Maricopa and Pima Counties. (Statement of Facts No. 8.) Having founded the defendant foundations to promote the interests of fee-for-service medicine, the defendant societies have con-

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[2] The undisputed facts upon which this motion for summary judgment is based are set forth in detail with citations to the record in the accompanying Statement of Undisputed Facts Supporting Plaintiff's Motion for Summary Judgment and Permanent Injunction and summarized here with references to that Statement.

[3] Medical and osteopathic physicians and surgeons and podiatrists who practice in Pima County or a county contiguous to Pima County may qualify for membership in the Pima Foundation for Medical Care ("Pima Foundation"). Medical and osteopathic physicians and surgeons may qualify for participating membership, and podiatrists and oral surgeons may qualify for cooperating membership, in the Maricopa Foundation for Medical Care ("Maricopa Foundation") no matter where in the State of Arizona they practice. The term "doctors" is used inclusively to refer to all foundation members.

trolled the activities of the foundations, including the activities at issue here.[1] (Statement of Facts Nos. 2,3.)

Defendants have repeatedly represented that their membership includes a substantial percentage of the fee-for-service physicians in their respective communities. (Statement of Facts No. 4). For example, in a bid dated May 18, 1979, the Maricopa Foundation represented that:

> The Maricopa Foundation for Medical Care was incorporated in 1969 and initially enrolled 80 percent of the active private practicing physicians in Maricopa County as participating members.
>
> There are approximately 1500 active practicing M.D.'s available to private patients and 250 Osteopathic physicians in Maricopa County. The Foundation has consistently maintained over 70% of the private practicing M.D.'s and approximately one-half of the Osteopathic physicians as members. The majority of the Podiatrists in Maricopa County also participate in the Foundation organization. (Exhibit to Affidavit of Alice McLain, dated July 5, 1979, Exhibit V to Statement of Facts.)

At the present time, over 1,000 of the licensed doctors in Maricopa County and over 400 of the licensed doctors in Pima County are members of the defendant foundations.

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[1] Under the By-Laws of both of the defendant foundations, the elected directors of the defendant societies have also served as the administrative members of the defendant foundations. In that capacity, the societies' directors have had the only general voting power on foundation affairs and have selected the foundations' trustees. (Statement of Facts.)

The Pima County Medical Society ("Pima Society") severed its relationship with the Pima Foundation in October, 1978, after the complaint in this action had been filed, and a consent judgment was thereafter entered against the Pima Society on November 17, 1978. The trustees of the Pima Foundation are now elected by the members of that foundation.

(Statement of Facts Nos. 31 and 32.) Thus, a substantial portion of the providers of fee-for-service medicine in Maricopa and Pima Counties have been involved in the practices at issue here.

B. Purpose

Defendants concede that the foundations were established by the defendant societies to promote the interests of fee-for-service medicine (Statement of Facts Nos. 3, 4), the dominant form of medical practice in which individual providers of doctors' services are paid on the basis of the particular services they render to individual patients.[8] In repeated communications to their members and other physicians, the defendant foundations have emphasized that they have been working to protect the interests of physicians who practice on a fee-for-service basis. (Statement of Facts No. 4, 36.)

A primary function of the defendant foundations since their inception has been the preparation and adoption of "uniform fee schedules" for doctors' services. Indeed, the only power granted to the members of either of the defendant foundations under the By-Laws of those associations has been the power "to vote on the adoption of . . . uniform fee schedules . . . by mail ballot." (Statement of Facts Nos. 12, 13.) The By-laws of both groups have also called for the establishment of standing fee schedule committees and have specifically authorized the foundations' trustees "to

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[8] *See American Medical Association v. United States*, 317 U.S. 519, 536, 63 S. Ct. 326, 332 (1943). Doctors who practice on a fee-for-service basis may practice alone or in a partnership or corporation with several other doctors. The key factor in fee-for-service practice is that the doctor (or his partnership or corporation) functions as an independent unit and is paid by the individual patient (or a third party which has assumed responsibility for that patient's doctor bills) on the basis of the services sold to the individual patient (rather than being paid a flat rate or a salary). *See generally, Council on Wage and Price Stability, Physicians Fees, A Study of Physicians' Fees* (1978) (Exhibit 2 to the Statement of Undisputed Facts Supporting Plaintiff's Motion for Partial Summary Judgment on the Issue of Liability with Supplemental References).

adopt and to propose to the [membership] uniform fee schedules for medical services" which when adopted by the majority vote of the [membership have been] binding upon all [members]." (Statement of Facts Nos. 13, 14, 20 & 21.) Doctors who apply for membership in the foundations have been required to complete and sign application blanks which contain an agreement "to be bound by any and all rules, regulations, committee decisions, fee schedules and the like, adopted by [the foundation]. (Statement of Facts Nos. 14, 22, 30, 34.)

In addition to determining the amounts which insurers must pay for professional services, the minimum standards promulgated by the defendant foundations have expressly limited the "professional payments" made under foundation-approved plans to "duly licensed (a) Physicians and Surgeons, (Doctors of Medicine), (b) Doctors of Dentistry, (c) Physicians and Surgeons (Doctors of Osteopathy), [and] (d) Doctors of Chiropody (Podiatrists)." (Statement of Facts No. 47, 49.) Thus, the services rendered by chiropractors, naturopaths, and other categories of duly licensed medical providers have been excluded from coverage in foundation-approved plans.

It is undisputed that the foundation members who have agreed to accept the amounts set in the foundation fee schedules as "full satisfaction" of their bills to patients insured under foundation-approved plans have been the *very same persons* who have decided by majority vote what those amounts would be.

Defendants have repeatedly indicated both to their member doctors and to the various specialty groups of doctors in Arizona that the fees set by their uniform fee schedules have been intended to approximate the usual and customary charges of the majority of doctors in their communities. (Statement of Facts Nos. 42, 63.) Defendants have repeatedly asked other associations of doctors to meet and agree on the fees and fee schedules to be used by their members and to report the results of their agreements to

the defendants. (Statement of Facts Nos. 60, 62.) After their adoption by majority vote of the foundation membership, the defendants' fee increases have been circulated to doctors throughout the State of Arizona. (Statement of Facts No. 65.)

This Court has already found that the fee schedules adopted by the doctor members of the defendant foundations have set the maximum fees to be paid to doctors by insurers for services rendered to patients enrolled in health insurance plans approved by the foundations. (Memorandum and Order of June 5, 1979, at 2, 6. See Statement of Facts No. 48.) Indeed, the minimum standards promulgated by the defendent foundations have required the insurers which underwrite foundation-approved plans to pay 100 percent of the fees charged by doctors for services covered under those plans up to the maximum amounts set in the foundation fee schedule.[6] (Statement of Facts Nos. 43 & 46.)

The insurers which underwrite foundation plans have had no vote at all on the fee schedules which determine the amounts they are required to pay for doctors' services under foundation-approved plans. As this Court noted in its Memorandum and Opinion of June 5, 1976, at 6-7, this is not a situation in which insurance companies have individually determined the maximum prices to be paid and the physicians have individually agreed to those terms. To the contrary, this is a situation in which defendants admit that

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[6] This requirement binds the insurer with respect to non-participating as well as participating doctors. In the case of a participating doctor, however, the patient's claim is automatically assigned and paid directly to the doctor and the doctor agrees not to bill the patient for payment in excess of the amount set by the foundation fee schedule. In either case, the patient may be required to pay a fixed deductible amount. (*See* Statement of Facts No. 70, 48).

they have decided by majority vote of their members what prices they will accept for their services, and insurers and other third party payors have been required to pay those prices.

C. The Conduct at Issue

What is at issue in this lawsuit is the determination of prices to be paid for doctors' services by majority vote of an association of doctors rather than the independent business judgment of individual doctors and insurers. The anticompetitive character of the foundation fee schedules is well-illustrated by the procedures which the defendants have admittedly followed in adopting and maintaining them.

It is undisputed that the defendant foundations have repeatedly polled the various specialty groups of doctors in Arizona on the prices charged and the relative value schedules and conversion factors used or preferred by their members. (Statement of Facts Nos. 57-59, 61.) On some occasions, the foundations have explicitly asked specialty groups of doctors to poll their members concerning the unit values and conversion factors they should use in the future. (Statement of Facts No. 64.) In response to those requests by defendants, numerous price communications and price agreements have occurred involving many doctors who were not even members of the defendant foundations. (Statement of Facts Nos. 57, 59, 61, 64.) For example, on April 14, 1977, the Maricopa Foundation's President wrote to the presidents and secretaries of at least fifteen different specialty societies, stating in part:

> The Maricopa Foundation for Medical Care is interested in maintaining as close-as-possible a relationship between the maximum allowance for Foundation plans and the usual and customary charges made by physicians in this area.

> To that end we would ask you to review with members of your specialty groups the present Foundation conversion factors (attached) and advise as to any changes you feel would be appropriate either on an overall conversion factor change or specific procedures where your group feels the payments are inequitable.
>
> We hope by these means to keep the Foundation concept viable in this community in protecting the private practice, free choice of physician method of health care delivery. (Exhibits MF-27 through MF-46 to Plaintiff's First Request for Admissions.)

Within a matter of weeks after that April 23, 1977 letter was sent to the specialty societies in Maricopa County, a number of those societies reported to the foundation that they had discussed and agreed upon the prices to be charged and the fee schedules to be used by their members. (*See* Exhibits MF-4 through MF-26 to Plaintiff's First Request for Admissions.) On the other hand, the representatives of several specialty groups notified the foundation that they would not participate in the foundation's price survey because it appeared to violate the antitrust laws. (Exhibits MF-20 through MF-22 to Plaintiff's First Request for Admissions.)

The defendants have also involved the specialty societies on a regular basis in their continuing efforts to revise, update and maintain the relative value schedules and conversion factors adopted by the foundation members. (Statement Facts No. 64.) On several occasions when new categories of doctors' services have been added to the coverage required by the foundations' minimum standards, the foundation fee schedules and payment criteria for those services have been prepared by associations of doctors who specialize in those fields of medicine. For example, in 1976 defendant Pima Foundation consulted the local pediatric society concerning the coverage and fees which the Pima Foundation should establish in its minimum standards for pediatric services. It was thereafter reported to the foundation that the society's members had "agreed to bill under

the 1964 California RVS 9040 with a factor of 11, which equals $14.40 with a Well-Baby Check office visit." (*See* Exhibit PF-109 to Plaintiff's First Request for Admissions.)

On repeated occasions defendant Maricopa Foundation has polled its member doctors for a "consensus" on prices and on the relative value schedules and conversion factors they used or desired to use. (Statement of Facts Nos. 50, 59, 63.) On such occasions, the membership has been informed that the foundation fee schedule should be "as close as possible" to the usual and customary fees charged by most doctors in the community. (Statement of Facts Nos. 42, 63.) On the heels of those price surveys, the foundation members have received proposed fee schedules recommended by the foundation's trustees with mail ballots for approval or disapproval of the proposed fee increases. (Statement of Facts Nos. 38-40.)

Typical of the Maricopa Foundations' membership polls is a June 7, 1977 letter to the foundation's members stating in part:

> [W]e feel it is time to survey the entire Foundation membership for their opinons concerning our fee schedule. While we do not feel that the Foundation Fee Schedule can be considered usual and customary for this area *we do feel strongly that it should approximate the majority of physicians charges."*

In order to arrive at a reasonable consensus we need your prompt response to the enclosed post card questionnaire.[7] *As soon as we tabulate this poll you will receive a ballot asking for your approval of any changes in the Foundation Fee Schedule.* (Exhibit MF-3 to Plaintiff's First Request for Admissions.)

In order to determine the allowable price set in a foundation fee schedule for a particular doctor's service, the user must refer to an agreed-upon relative value schedule and an agreed-upon unit conversion factor. (Statement of Facts No. 49.) Relative value schedules are lists or compilations of doctors' services which assign a comparative unit value to each service listed. (Statement of Facts No. 52.) Unit conversion factors are number or dollar figures used to multiply the unit value found in a relative value schedule for any doctor's service into a dollar figure payable for that service. (*See* Statement of Facts No. 53.) The foundation fee schedules provide unit conversion factors for six categories of medicine to be used with certain agreed-upon relative value schedules. (Statement of Facts No. 54.)

The defendant foundations have admittedly adopted, revised, published, circulated and encouraged the agreed-upon use by doctors of relative value schedules which were initially prepared and published by the California Medical

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[7] The post card questionnaire referred to in the letter was the following (Exhibit MF-2 to Plaintiff's First Request for Admissions (Emphasis added).):

Maricopa Foundation for Medical Care-1977 Fee Schedule

Write a single dollar conversion factor in your practice category.

Medicine_____ Surgery_____ Clinical Lab_____

Radiology_____ Anesthesiology_____

Please indicate the Relative Value Guide you are presently using.

	1964	1969	1974
California Relative Value Schedule	___	___	___

*Other (specify)*_____

Your speciality or field of practice_____
please print

Your name_____
please print

Association, The American College of Radiology and the American Society of Anesthesiology. (Statement of Facts No. 50.) In recent years, both the California Medical Association and the American College of Radiology have been enjoined by consent orders entered in proceedings before the Federal Trade Commission from preparing, revising, publishing or circulating the same relative value schedules which the defendants are continuing to update and revise in concert with their doctor members and other groups of doctors.* (Statement of Facts No. 51.)

Defendants have frequently adjusted the maximum prices payable for certain procedures by changing the unit values assigned to those procedures. (Statement of Facts No. 58.) For example, the maximum allowable price set by defendant Maricopa Foundation for a routine office visit was increased by 50 percent when the Maricopa Foundation increased the unit value accorded to such a visit from 1.0 to 1.5. On numerous occasions when defendants have adjusted the unit values for certain procedures in their adopted relative value schedules, they have acted in concert with groups of doctors who specialize in the procedures in question. (Statement of Facts Nos. 57-62. 64.)

While an increase in the relative value assigned to a specific procedure has only increased the maximum price for that procedure, an agreed-upon increase in the foundation conversion factor for any category of medicine has had the effect of increasing the prices allowed for all the doctors' services included in that medical category. (Statement of Facts No. 55.) Consequently, the information needed for a collective price increase for thousands of doctors' services has been provided to the foundation's doctor members on

* Consent decrees enjoining the agreed-upon use of relative value schedules by doctors have also been entered in a number of cases to date. *See, e.g.*, Reply Memorandum in Support of Plaintiff's Motion for Partial Summary Judgment on the Issue of Liability, at 10-11.

postcard ballots. On repeated occasions, the foundation's doctor members have voted by overwhelming margins to raise the price levels determined by the foundation conversion factors. (Statement of Facts Nos. 39-40.)

After their adoption, the foundation fee schedules have been published and circulated to doctors throughout the State of Arizona, including both members and nonmembers of the defendant foundations. (Statement of Facts Nos. 37, 65, 66, 67.) They have been mailed to foundation members, published in the monthly publications of both defendant societies, and mailed with applications for foundation membership to doctors who were not foundation members. (Statement of Facts Nos. 66, 68.)

The foundations have provided advance notice of their price increases to the insurers which underwrite foundation-approved plans, (Statement of Facts No. 74), and it is undisputed that the agreed-upon increases in defendants' fee schedules have resulted in increases in the premiums charged on those plans. (Statement of Facts Nos. 75.)

On several occasions, the increased conversion factors adopted by the Maricopa Foundation's membership have been sent to the Pima Foundation's Board of Trustees, and that Board has sent the same conversion factors to the Pima Foundation's membership for approval. (Statement of Facts Nos. 72.)

The record also establishes that foundation conversion factors have been increased to levels which were significantly higher than the average and median conversion factors charged by most doctors in Arizona at the time that the increase was approved. For example, the record clearly shows that in October of 1975 the trustees of defendant Maricopa Foundation recommended an increase in that foundation's conversion factors to a level that was substantially higher than the average charges of physicians statewide as shown in the results of a statewide price survey

conducted by the Arizona Medical Association and reviewed by the foundation's trustees immediately before they voted to recommend the foundation fee increase. (Statement of Facts Nos. 71.)

D. Effects of the Conduct at Issue

The agreed-upon relative value schedules and conversion factors adopted by the defendant foundations have clearly provided a comprehensive pricing system for doctors who practice on a fee-for-service basis in Arizona. It is undisputed that the periodic adoption of those comprehensive fee schedules has been the occasion for widespread meetings, discussions and agreements among doctors who sell the same services in the same community on a fee-for-service basis concerning the prices to be paid for those services and the relative value schedules and conversion factors which the doctors will use in determining those prices. By increasing their agreed-upon conversion factors from time to time, the members of the defendant foundations have agreed on overall increases in the prices set by the foundation fee schedule. (Statement of Facts No. 55.) On other occasions, defendants have increased the prices payable for certain procedures by increasing the unit values for those procedures; those specific price increases have not required a ballot of the foundation membership but have been published to all foundation members as well as to the insurers who must pay the increased prices. While the members of the California Medical Association and the American College of Radiology (including the members of the Arizona Radiological Society) have been enjoined from preparing, revising, publishing, or circulating their relative value schedules, the defendant foundations are performing those functions in their place here in Arizona.

Manifestly, the fee schedules adopted by foundation members provide the same maximum fees to be paid to all doctors regardless of their experience, training, expertise or reputation. It is also clear that the foundations' uniform fee schedules have led to uniform pricing, for the Maricopa

Foundation, which processes the doctors' bills, has admitted that 85 to 95 percent of foundation members bill at or above the rates set in the foundation fee schedules. This admission of uniform pricing is corroborated by the fee data collected by the Arizona Medical Association and the Health Insurance Association of America during 1975 and 1976, showing that the average fees charged by Arizona doctors over the level set in the fee schedules adopted by the foundation members. (Statement of Facts No. 71.) That data further indicates that after an increase in the level of fees set in the foundation fee schedule has been adopted by the foundation members, overall doctors' fees have risen to that level. (Statement of Facts No. 72.) It is undisputed that increases in doctors' prices result in increases in premiums for insurance plans which cover doctors' services. (Statement of Facts Nos. 75-76.)

It is also clear that reimbursement schedules for doctors can be determined by thrid party payors rather than doctors. Blue Cross and Blue Shield of Arizona, for example, provides doctors' services to its insured through a panel of doctors who decide individually whether or not to accept the reimbursement formula set by Blue Cross and Blue Shield. (See Exhibits A and B to the Alice McLain Affidavit; dated July 5, 1979, *Group Life & Health Insurance Co. v. Royal Drug Co.*, 995 S.Ct. 1067, 1072 (1979).

That the defendant foundations can provide administrative and peer review services to insurers without setting the fees which the insurers must pay to doctors has been proven by the defendants' own commercial experience. In a bid which defendant Maricopa Foundation recently submitted to the Arizona Department of Economic Security (Exhibit E-3 to Alice McLain Affidavit, Dated July 5) the foundation reported that it had successfully provided administrative and peer review services for the State of Arizona's Comprehensive Medical and Dental Program for Foster Children and sought to continue providing those services. Under Arizona law, maximum fees paid to doctors

under The Foster Children Program must be determined independently by the Department of Economic Security. (Exhibit C-1 to McLain Affidavit, ; Ariz. Rev. Stat. Ann. § 8-512(C). Accordingly, the Department has itself established a schedule of maximum fees payable for doctors' services under its Foster Children Program (Ariz. Rev. Stat. Ann. § 8-512(c)). Without setting the fees to be paid to doctors, therefore, the Maricopa Foundation has provided administrative and peer services for The Foster Children Program, with non-member and member doctors alike participating in the peer review function.

III.
DEFENDANTS' PRICE-FIXING IS UNLAWFUL UNDER RULE OF REASON ANALYSIS

A. The Conduct At Issue In This Case Has Been Anticompetitive In Purpose and Effect.

In *National Society of Professional Engineers v. United States*, 435 U.S. 679, 98 S.Ct. 1355 (1978), the Supreme Court reviewed "the contours of the Rule of Reason"* and discussed the application of that rule to a professional society's ethical rule against competitive bidding by its members. 435 U.S. at 687, 98 S.Ct. at 1363.

> The Court made it clear that contrary to its name, the Rule does not open the field of antitrust inquiry to any argument in favor of a challenged restraint that may fall within the realm of reason. Instead, it focuses directly on the challenged restraint's impact on competitive conditions. 435 U.S. at 688, 98 S.Ct. at 1363.

In *Professional Engineers*, the Supreme Court ruled that "an agreement that 'interfere[s] with the setting of price by free market forces' is illegal on its face." 435 U.S. at 692, 98 S.Ct. at 1365 (citation omitted). Even though the ban on competitive bidding at issue in *Professional Engineers* did

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* The development of the standard of reasonableness under the Sherman Act is more fully discussed in plaintiff's concurrent motion for reconsideration of the Memorandum and Opinion of June 5, 1979.

not in the Court's judgment constitute "price-fixing as such," the Court nevertheless held that "no elaborate industry analysis is required to demonstrate the anticompetitive character of such an agreement" 435 U.S. at 692, 98 S.Ct. at 1365.

> It operates as an absolute ban on competitive bidding, applying with equal force to both complicated and simple projects and to both inexperienced and sophisticated customers. As the District Court found, the ban 'impedes the ordinary give and take of the market place,' and substantially deprives the customer of 'the ability to utilize and compare prices in selecting engineering service.' On its face, this agreement restrains trade within the meaning of § 1 of the Sherman Act. 435 U.S. at 692-93, 98 S.Ct. at 1365-66. (citation omitted).

In this case, the record exposes undisputed horizontal price-fixing which has had a direct and substantial impact on competitive conditions in the market for fee-for-service medicine. In a medical marketplace where each fee-for-service physician possesses a significant degree of natural monopoly power, the defendants have enlisted a substantial percentage of those physicians in a doctors' cartel which has determined by majority vote of its membrs the professional fees to be paid by third parties for medical services. With their admitted objective being the promotion of the commercial interests of fee-for-service physicians, the defendant foundations have established, maintained and circulated uniform and comprehensive pricing systems for fee-for-service doctors. Their uniform fee schedules and fee increases have resulted in uniform pricing and have suppressed the individual pricing of medical services by fee-for-service doctors and third party payors. No elaborate analysis is needed to discern the anticompetitive impact of such conduct.

Because the conduct at issue here *does* constitute "price-fixing as such,"[10] its anticompetitive character is even plainer than that of a ban on competitive bidding. In *Professional Engineers*, the Court was presented with "an agreement among competitors to refuse to discuss prices with potential customers until after negotiations [had] resulted in the initial selection of an engineer." 435 U.S. at 692, 98 S.Ct. at 1365. In this case, the Court is presented with an agreement among competitors not to discuss prices at all with third party payors, but rather to set by agreement among themselves schedules of uniform prices which they will accept from those third party payors. The record clearly demonstrates the anticompetitive character of those horizontal price agreements.

1. Defendants' Market Power Is Significantly Greater Than That of Ordinary Trade Associations.

The market power of the defendant foundations, whose membership comprises a substantial percentage of the fee-for-service doctors in Maricopa and Pima Counties, is far greater than that of an ordinary trade association. It has been widely recognized that "[e]ach fee-for-service doctor has a substantial amount of monopoly power over his individual patients as a result of their medical ignorance and dependency and their willingness to pay." Havighurst, *Health Maintenance Organizations and the Market for Health Services*, 35 Law and Contemp. Prob. 716, 768 (1970) (Hereinafter "Havighurst, HMOs").

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[10] Plaintiff respectfully suggests that because the conduct at issue here constitutes "price-fixing as such," that conduct is more appropriately judged under the *per se* standard of analysis. This position is more fully briefed in plaintiff's motion for reconsideration of the Order of June 5, 1979, and will not be repeated in this memorandum. It must be noted however, that in *Professional Engineers* the Supreme Court expressly distinguished price-fixing from that conduct of a professional trade association which is appropriately analyzed under the Rule of Reason. 435 U.S. at 692, 98 S.Ct. at 1365.

> A physician possesses a degree of natural monopoly power over his patients and this power is enhanced by the presence of insurance which relieves patients of concern about fees or other costs. Kallstrom, *Health Care Cost Control by Third Party Payors: Fee Schedules and the Sherman Act*, 1978 Duke L.J. 645, 660 (hereinafter "Kallstrom, *Fee Schedules*")

As explained in a recent law review article which was cited by this Court in its Memorandum and Order of June 5, 1979:

> The medical profession differs from many other trades because of the substantial market power, bordering on monopoly power, which every doctor and hospital wields in dealing with the consuming public. . . .
>
> Nevertheless, professional organizations in the health care sector resemble ordinary trade associations in that they represent and act to further the collective interests of the professions . . . It has been suggested that, in a subtle fashion, the very independence and power of their members makes these organizations even more dangerous than traditional trade associations because anticompetitive practices can be maintained within them with fewer formalities than is usually the case. Kallstrom, *Fee Schedules, supra* at 692, n. 197 (citations omitted).

It is therefore, no exaggeration to state that the defendant trade associations, whose membership comprises a substantial portion of the fee-for-service doctors in their communities, are in effect combinations of monopolists with unique power as sellers in the medical marketplace.

2. Defendants Have Cartelized the Pricing of Doctors' Services.

From their inception the defendant foundations have served the function of establishing and maintaining "uniform fee schedules" which were adopted and revised by majority vote of a substantial portion of the fee-for-service doctors in their communities.

By setting a cartel price for the services they provide to insured persons, the foundations' member doctors have directly restricted independent pricing of doctors' services and have curtailed the bargaining power which third party payors might have exercised in the absence of a doctors' cartel. Rather than negotiate with individual fee-for-service providers in Arizona on the prices to be paid for professional services, third party payors have been faced with a doctors' cartel that has already decided by a majority vote of its members what prices they will accept from third parties for medical services to insured patients.

In a recent article, Professor Havighurst aptly described the anticompetitive character of cartel pricing by foundations for medical care:

> Under the procompetitive premise of the antitrust laws, FMCs [foundations for medical care] and similar [professionally controlled health financing plans] should be recognized as part of a profit-maximizing strategy of a coalition of monopolists. Case law suggesting that the fixing of maximum prices is regarded no more favorably than minimum-price fixing would seem appropriately invoked to curb private price regulation undertaken by a cartel. In many market circumstances, an FMC could be challenged as an exclusionary tactic of a monopolist or as the product of a conspiracy to monopolize the provision of medical care. The most likely theory of attack on FMC-type efforts, however, would be under section 1 of the Sherman Act as a combination in restraint of trade lacking virtues sufficient to redeem its several anticompetitive features. The fundamental premise of the antitrust laws, which can be contested in a legislative but not in a judicial forum, is that the competitie solution is always preferable to the cartel's. Havighurst, *Professional Restraints on Innovation in Health Care Financing*, 1978 Duke L.J. 303, 377-378 (footnotes omitted) (hereinafter Havighurst, *Professional Restraints.*)

3. Defendants' Cartel Pricing Has Suppressed the Bargaining Power of Third Party Payors.

In determing by agreement what professional fees should be paid by insurance companies and other third party payors, the defendants and their doctor members have not only suppressed independent pricing by doctors, they have usurped an economic function which would otherwise have been performed by the party responsible for paying those fees. It is undisputed that the foundations' fee schedules and minimum standards have been formulated by defendants and their members in a completely horizontal combination. The insurance companies and other third parties that underwrite foundation-approved plans have had no vote whatsoever on the professional fees they must pay under those plans.

If it were not immediately obvious that the determination of professional fees to be paid by insurers through associations of doctors devoted to fee-for-service practice was inherently anticompetitive, the defendants' conduct has made their restrictive purpose clear. Under the minimum standards promulgated by the defendants, professional fees can only be paid to medical or osteopathic physicians and surgeons, podiatrists and dentists; the services of duly-licensed chiropractors, naturopaths and other medical practitioners have been excluded from coverage. Consequently, persons insured under foundation-approved plans have been limited in their choice of medical treatment to the categories of treatment in which the defendants' members engage, and the insurers' determination of the types of medical treatment to be covered has been made for them by a doctors' cartel.

Just recently the Supreme Court commented on the "serious anticompetitive consequences" which result from this type of physician control over the professional payments made by third party payors. *Group Life & Health Insurance Co. v. Royal Drug Co.*, 99 S.Ct. 1067, 1083-84, n. 40 (1979). The Court warned that *exempting provider agree-*

ments from the antitrust laws would be likely in at least some cases to have serious anticompetitive consequences. Id. (emphasis added). Noting that "physicians and other health care providers typically dominate the Boards of Directors of Blue Shield plans," the Court surmised that as a result of such physician control *"there is little incentive . . . to minimize costs, since it is in the interest of the providers to set fee schedules at the highest possible level." Id.* at 1083-84, n. 40 (emphasis added). This physician domination of insurers, the Court noted, was "said to have resulted in rapid escalation of health care costs to the detriment of consumers generally." *Id.* (citation omitted.)[11]

It is noteworthy that the members of the Supreme Court were unanimous in their concern over the anticompetitive impact of horizontal combinations in the health care industry. Even those Justices who dissented from the majority ruling in *Royal Drug* commented that a horizontal conspiracy of providers which pressured an insurer to go along with its arguments, would constitute an "illegal conspiracy" which was "neither necessary nor related to the insurer's effort to satisfy its obligations to its policyholders." *Id.* at 1094 (Brennan, J., dissenting).

Not only is the horizontal price fixing of the defendants unnecessary to the insurer's efforts to satisfy its policy obligations, it is a direct and severe restraint on the bargaining power of the insurer in negotiating reimbursement sched-

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[11] See Staff Report to the Federal trade Commission and Proposed Trade Regulation Rule, *Medical Participation in Control of Blue Shield and Certain Other Open-Panel Medical Prepayment Plans* (April 1979); CCH Trade Reg. Rep. No. 384, at 6 (May 7, 1979).

It should perhaps be noted that the one-time relationship between Blue Shield of Arizona and the Arizona Medical Association was severed several years ago. More recently, the Ohio State Medical Association agreed to sever its relationship from the Ohio Blue Shield Plan as a term of the consent judgment entered in *State of Ohio v. Ohio Medical Indemnity, Inc.*, 1976-2 CCH Trade Cas. ¶ 61,128 (S.D. Ohio, filed September 16, 1976) (copy of consent judgment attached as Exhibit F to Statement of Facts.)

ules with fee-for-service physicians. A recent decision of the Court of Appeals for the District of Columbia Circuit held that a similar restraint on the bargaining power of sellers in professional sports was unlawful under Rule of Reason analysis. *Smith v. Pro Football Inc.*, 593 F.2d 1173 (D.C. Cir. 1978), held that the player selection system of "draft" of the National Football League ("NFL") was a violation of section 1 of the Sherman Act under the Rule of Reason because it deprived football players of their "real bargaining power" in negotiating with NFL teams. Noting that there were less anticompetitive alternatives to the draft system the court held that "this level of restraint cannot be justified." 593 F.2d at 1187. For similar reasons, the Court of Appeals for the Eighth Circuit has held that the NFL's Rozelle Rule is unlawful. *Mackey v. National Football League*, 543 F.2d 606, 621-622 (8th Cir. 1976), and the Federal District Court for the Northern District of California has held the NFL's Rozelle Rule, player draft rule, one-man rule, tampering rule and Standard Player Contract rule unlawful under Rule of Reason analysis. *Kapp v. National Football League*, 390 F. Supp. at 82. Although those cases did not involve the severe anticompetitive impact of a direct restraint on price, the restriction of the bargaining power of football players under NFL rules was deemed an impermissible restraint upon the market for players' services.

4. Defendants' Challenged Practices Have Had a Direct and Substantial Impact on Prices.

A primary function of the defendant foundations since their inception has been the preparation and adoption of "uniform fee schedules" for doctors' services. So basic is price fixing to the function of those trade associations that the principal incident of membership in the foundations has been the power to vote on "uniform fee schedules." Indeed, the very By-Laws of the defendant foundations expressly provided for the establishment of standing fee schedule committees and specifically authorized the foun-

dations' trustees to prepare and recommend changes in the foundation fee schedules which could only be adopted by mail ballots of the foundations' member doctors. The procedures by which the defendants have maintained and revised those fee schedules through widespread price surveys and price agreements among the foundations' member doctors and the various specialty groups of doctors in Arizona have clearly been intended to result in agreed-upon price levels for doctors.

Examination of the business records of the defendants reveals that defendants have consistently strived to keep their "uniform fee schedules" at a level approximating "the majority of physicians' charges" and have so advised their members. The repeated polls, meetings, discussions and agreements among doctors which the defendants have instigated regarding the prices to be charged and the relative value schedules and conversion factors to be used by doctors have involved future as well as current pricing information, and have included both members and nonmembers of the foundations. Defendants have made it clear that the fee schedules they have proposed to their members for adoption represented a consensus on the prices which doctors in the community would be charging in the period after the fee schedules were adopted, and it is established that over 85 percent of the foundations' member doctors have billed their fees at or above the levels set in those fee schedules. Thus, the record clearly shows that the defendants' fee schedules were intended to function and did function as uniform fee schedules for foundation members.

It is particularly significant that both the preliminary price agreements encouraged by the defendants and the adoption of fee schedules by majority vote of the defendants' doctor members were manifestly intended to result in collective price increases. Even if the prices charged by doctors had not been uniform at the time a new fee schedule was adopted, the agreement of defendants' doctor members to raise their prices simultaneously operated as a

direct restraint on independent pricing decisions. In this case, the anticompetitive character of an agreement to raise prices at a given time was exacerbated by the defendants' widespread communications that the proposed price increases represented a "consensus" and would approximate the charges of most doctors in the community.

Through defendants' publication of the agreed-upon increases in the fees set by the foundation fee schedules, doctors who might not have considered their current prices too low have been reminded that the majority of the foundations' doctor members consider the newly increased fee schedule to be appropriate. If there could be any doubt that the defendants' repeated communications of price increases and price agreements have had a substantial anticompetitive impact, the admitted fact that 85 to 95 percent of foundation members bill at or above the level of fees set by the foundation fee schedule would surely resolve it.

It is undisputed that increases in the doctors' fees set in the foundation fee schedule result in increases in the premiums charged on foundation-approved health plans, and that general increases in doctors' prices result in general increases in health insurance premiums. Since the admitted facts in this case establish that 85 to 95 percent of the doctor members of the foundation bill at or above the level of fees set by the foundation fee schedule and the foundation membership includes a large percentage of the fee-for-service doctors in Maricopa and Pima Counties, it follows *a fortiori* that increases in the level of fees set by the foundation fee schedule have resulted in general fee increases for many doctors in those counties, and those fee increases have in turn resulted in increases insurance premiums.

There is no dispute that the agreed-upon relative value schedules and conversion factors adopted by the foundations' doctor members provide a comprehensive pricing system for fee-for service doctors. The establishment and maintenance of a uniform pricing system is by itself a substantial anticompetitive result of the defendants' activities.

In the absence of an agreed-upon pricing system, individual doctors might develop their own pricing methods and bargain individually with third party payors on the prices they would accept for their services. By producing and publishing a consensus on appropriate fees and fee schedules, the defendants have suppressed the diversity of doctors pricing which might otherwise prevail.

Indeed, the setting of uniform prices for all doctors' services irrespective of the training, experience, reputation and expertise of the individual doctor is a significant restraint in itself. A third party payor might well tend to offer a lower price to a novice doctor than to a renowned specialist, but the foundations dictate that all be paid the same. In the analogous area of legal fees, one would naturally balk at being asked to pay to an associate fresh out of law school the same hourly fee that an experienced, highly-reputed attorney would command. *See, e.g.*, Opinion and Order of April 16, 1979 in *In re Arizona Dairy Products Litigation*, No. CIV 74-569 A PHX CAM (D. Ariz., filed [date of complaint]), at 3-4 (finding that rates ranging from $60.00 per hour for a new associate in his/her first year out of law school up to $90.00 for an attorney not yet four years out of law school were excessive in the circumstances of that case, Judge Muecke reduced certain attorneys' fees to "what the Court feels are reasonable rates of compensation for persons of comparable skill and experience in the Phoenix area.") Like an attorney's hourly rate, a doctor's conversion factor might be set in accordance with the individual doc-

tor's experience and training were it not for the uniform pricing established by the defendants.[18]

The anticompetitive impact of uniform pricing by professionals was recognized and condemned by the district court in *Goldfarb v. Virginia State Bar*, 355 F. Supp. 491 (E.D. Va. 1973). Noting the impact which agreed-upon fee schedules necessarily have on entry pricing by new members of a profession, the court held such fee schedules "to be repugnant to the philosophy of the Sherman Act."

> This type of price-fixing has been held under other circumstances to be repugnant to the philosophy of the Sherman Act. *Plymouth Dealers Ass'n v. United States*, 279 F.2d 128 (9th Cir. 1960). It is contrary to the spirit of competition which sustains a free enterprise system in that it prevents competitors from using their own judgment in determining the value of their own services. *Keifer-Stewart Co. v. Seagram and Sons*, 340 U.S. 211, 213 (1951).

The district court explained the impact of fee schedules on consumers:

> There is no distinction between the benefits ascribed to the minimum fee schedule by its advocates and those existing in a minimum sales price if, for example, the latter were to be adopted by General Motors and Ford Motor Company as to suggested sales prices for comparable automobiles. In each instance, a new dealer and a new lawyer, both unfamiliar with the customary charges in the field, would find such a

[18] In fact, many insurers do adjust their allowable payments for doctors' services in accordance with the "usual fees" of the individual provider. (*See, e.g.*, Exhibits to McLain Affidavit describing the payment criteria of Blue Cross and Blue Shield of Arizona.) While the "UCR" reimbursement method has been criticized as inflationary, it is relevant here to note that many insurers have, in the exercise of their independent business judgment, chosen *not* to use a reimbursement schedule which provides uniform payments to all doctors, but the pricing uniformity encouraged by the defendants' horizontal price agreements suppresses the individual development of varying "usual fees" by doctors.

> minimum fee or sales price schedule helpful in setting charges. In each instance an adequate fee or price would insure a margin of profit adequate to assure further research and development or continued legal education. In each instance the public would be assured, by an examination of such schedule, that what was being charged was in line with what was generally charged in the field. Yet in none of these instances would a member of the public have any better idea that the fee or price was reasonable after he had seen the schedule than he did before. *Id.*

The conclusion of the district court that the professional fee schedules violated the Sherman Act was, of course, confirmed by the Supreme Court. 421 U.S. 773, 95 S.Ct. 2004 (1975).

More recently, another district court reviewed the coordination and publication of rate schedules by a rate bureau for common carriers. *United States v. Southern Motor Carriers Rate Conference, Inc.*, 467 F. Supp. 471 (N.D. Ga. 1979). Like the defendants in this case, the rate bureau had prepared, proposed, published and circulated rate schedules, which the district court held to be a "naked price restraint" which violated the Sherman Act "at its most sensitive spot." 467 F. Supp. at 486. Holding that the horizontal coordination of rates was unlawful under both *per se* analysis and the Rule of Reason, the court granted plaintiff's motion for summary judgment and injunctive relief. *Id.* at 486-87.

The evidence in this case corroborates what the long line of cases dealing with horizontal price fixing has taught:

> The aim and result of every price-fixing agreement . . . is the elimination of one form of competition. *United States v. Gillen*, 1979-1 CCH Trade Cas. ¶ 62,627 at 77,579 (3d Cir. 1979), quoting *United States v. Trenton Potteries Co.*, 273 U.S. 392, 397 (1926).

Because defendants' challenged practices have had a direct and substantial impact on the pricing of individual doctors' services, it is outside the pole of the Sherman Act under the Rule of Reason.

B. This Level Of Price Restraint Is Patently Unreasonable.

As this Court recognized in its Memorandum and Order of June 5, 1979, it is of no consequence that the foundations' member doctors technically remain free to charge whatever price they wish, as they have agreed in advance to accept the amount determined by the foundation fee schedule in full consideration for their services. Slip Op. at 6. By defining the level of fees which doctors will accept from third party payors, the defendants have directly impinged "the freedom of [individual doctors and insurers] and thereby restrain[ed] their ability to sell in accordance with their own judgment." *Kiefer-Stewart Co. v. Joseph E. Seagram & Sons*, 340 U.S. 211, 213, 71 S.Ct. 259, 260 (1951). When competitors agree on a "starting point" or "range" of prices fro the services or products they sell, an essential form of competition is eliminated regardless of whether the agreed-upon prices are maximum or minimum, uniform or list prices and whether the agreement is mandatory or voluntary.

> Common sense tells us that there is no need for competitors to meet, agree upon content, print and circulate 'list prices' that are never to be looked at. *Plymouth Dealers' Ass'n of Northern California v. United States*, 279 F.2d 128, 133 (9th Cir. 1960). *See also Vandervelde v. Put and Call Brokers and Dealers' Ass'n*, 334 F. Supp. 118, 134 (S.D.N.Y. 1972).

Although horizontal price restraints are universally judged under the *per se* rule, several courts have held in the alternative that price agreements which were strikingly similar to those at issue in this case were also unlawful under Rule of Reason analysis. For example, *United States v. Utah Pharmaceutical Ass'n*, 201 F. Supp. 29 (D. Utah

1962), *aff'd*, 371 U.S. 24, 83 S.Ct. 119 (1962), involved an association of independent pharmacists which adopted a pricing schedule and successive revisions, distributed them to members throughout the State of Utah and encouraged the members to use the schedule for the pricing of prescription drugs. 201 F. Supp. at 34. Finding that "one cannot lawfully agree with others to fix the price of goods in commerce merely because of professional credentials or because such price-fixing also touches upon professional fees," the district court held that the association's price schedules were *per se* illegal. 201 F. Supp. at 35, *citing United States v. Socony-Vacuum Oil Co.*, 310 U.S. 150, 60 S.Ct. 811 (1940), and *United States v. Trenton Potteries Co.*, 273 U.S. 392, 47 S.Ct. 377 (1947). Alternatively, however, the court held that the association's price schedules were also unlawful under Rule of Reason analysis.

> *There could not be considered reasonable under any circumstances a conspiratorial agreement, and the distribution and promotion of implementing price schedules, among those in a dominant position in the business and profession of dispensing drugs within the State of Utah, which carried to the extent sought by the Association would almost completely remove price competition in the field of prescription drugs.* The good faith and professional standing of those concerned being fully accepted, if such a system were accepted as reasonable, any other similar group of well intentioned men could accomplish the same results in their own businesses through their own associations. This result, with any effective agreement to that end, is unacceptable to the antitrust laws. It is the duty of a Court to apply these laws in easy cases as well as hard cases, and as against well intentioned parties to an agreement conspiratorial only in law as well as against conspirators in sinister sense which, of course, cannot apply to the parties before the Court. Even under the 'rule of reason,' as said in *Board of Trade of City of Chicago v. United States, supra*, 'The true test of legality is whether the restraint imposed is such as

> merely regulates and perhaps thereby promotes competition or whether it is such as may suppress or even destroy competition.' The system promoted by the Association does not meet this test[.]
> 201 F. Supp. at 35-36.

Accord, Northern California Pharmaceutical Ass'n v. United States, 306 F.2d 379 (9th Cir.), *cert. denied*, 371 U.S. 262, 83 S.Ct. 119 (1962) (holding almost identical facts sufficient for criminal liability under section 1 of the Sherman Act.) 306 F.2d at 391. The extensive analysis of the Ninth Circuit in *Plymouth Dealers Ass'n, supra*, and of the District Court for the Southern District of New York in *Vandervelde v. Put and Call Brokers and Dealers' Ass'n, supra*, would also support a holding of illegality on a Rule of Reason standard, though the price fixing at issue in those cases was held to be unlawful *per se*. As the district court noted in *United States v. Southern Motor Carriers Rate Conference*, 467 F. Supp. at 486-87, n. 11, the focus of inquiry in a price fixing case under the Rule of Reason continues to be on the effect of the challenged conduct on price competition.

> The essence of the antitrust laws is to ensure fair price competition in an open market. *Reiter v. Sonotone Corp.*, 47 U.S.L.W. 4672, 4675 (Sup. Ct., June 11, 1979).

Because the conduct at issue in this case operates as a direct restraint on "the setting of price by free market forces," it is "illegal on its face" under the Rule of Reason. *National Society of Professional Engineers v. United States*, 435 U.S. at 692, 98 S.Ct. at 1365.

C. The Conduct At Issue In This Case Is Far More Restrictive Than Necessary For Any Legitimate Aims The Defendants Might Assert.

If the defendants' objective were simply to establish a panel of fee-for-service doctors to provide doctors' services to patients covered under certain types of health insurance,

there would be no need for the professional fees paid by insurers to be determined by a doctors' cartel. Insurers and other third parties are fully capable of devising a reimbursement schedule for doctors' services and organizing a panel of fee-for-service doctors who would decide individually to accept that reimbursement schedule. *Professional Restraints, supra,* at 326-334; Kallstrom, *Third Party Payors, supra,* at 660 (insurer initiated fee schedules are a means of lowering health care costs by counteracting the monoply power of physicians; *see* Exhibits to McLain Affidavit.)

Were it defendants' purpose to contain the price of fee-for-service medicine, that could be accomplished far more effectively by the foundations' doctor members charging lower prices to all patients than by their repeated cycles of surveys, meetings and agreements on price increases and uniform fee schedules. Indeed, courts and commentators alike have recognized that the control of insurance reimbursement schedules by doctors' associations has had an inflationary, not a deflationary, effect on doctors' prices. *E.g., Group Life and Health Insurance Co. v. Royal Drug Co.,* 99 S.Ct. at 1083-84, n. 40; Havighurst, *Professional Restraints, supra* at 377 (FMCs should be recognized as part of a profit-maximizing strategy of a coalition of monopolists). Under these circumstances the control which the defendant foundations and their voting members have exer-

cised over the professional fees paid by third parties merits searching scrutiny.[13]

As one commentator cited in this Court's recent Memorandum and Opinion of June 5, 1979 has concluded,

> Fee schedules that are developed with any involvement by a medical association of any kind should be condemned per se. Fee schedules that are initiated as the independent effort of insurers, however, and are negotiated with doctors who make their decisions individually, should be encouraged. This kind of arrangement should be approved unless there is affirmative proof that it has been abused—that it is a sham that hides an agreement among doctors, perpetrated either by a deliberate combination to fix prices or through the more subtle pressures of a medical association . . . .
>
> *Perhaps the most blatant examples of concerted provider involvement in fee setting arrangements are the FMCs* (Foundations for Medical Care). Kallstrom, *Third Party Payors, supra* at 680.

The Maricopa Foundation has already demonstrated that the defendant foundations can provide administrative and peer review services to a health care program without also

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[13] A recent Staff Report to the Federal Trade Commission concludes that medical participation in the control of many medical financing plans has resulted in a situation where "the price paid for physicians' services responds to the will of the medical profession and the 'house of medicine' decides whether and how much the plans will pay for the services of non-physicians," and recommends that the Commission commence a rule-making proceeding and approve a proposed rule providing that "it is an unfair method of competition for any physician organization directly or indirectly to control or to participate in controlling any open-panel medical care prepayment plan." Staff Report to the Federal Trade Commission and Proposed Trade Regulation Rule, *Medical Participation in Control of Blue Shield and Certain Other Open-Panel Medical Prepayment Plans*, 1-2, 32 (April 1979), 913 BNA Antitrust Trade Reg. Rep. E-1 (May 10, 1979).

determining the prices paid to doctors under that program. Although under Arizona law the reimbursement schedule for the States Comprehensive Medical and Dental Program for Foster Children must be determined on an independent basis by the Arizona Department of Economic Security, the Maricopa Foundation has been able to perform both administrative and peer review services for that program. (Exhibit 1 to McLain Affidavit: Ariz. Rev Stat. Ann. § 8-512(c)). Thus, the price-fixing activities at issue in this case are *not* necessary to the peer review and administrative services performed by the defendant foundations.

Because the price-fixing activities of the defendant foundations have been far more restrictive than necessary to achieve any legitimate end of the defendant associations, those activities should be held unlawful restraints of trade under the Rule of Reason analysis adopted by this Court. *Smith v. Pro Football, Inc.*, 593 F.2d at 1183-89; *Mackey v. National Football League*, 543 F.2d at 621-22; *Kapp v. National Football League*, 390 F. Supp. at 82-83.

IV

PLAINTIFF IS ENTITLED TO SUMMARY JUDGMENT UNDER THE RULE OF REASON

The material facts which establish the anticompetitive purpose and effect of the price-fixing activities challenged in this lawsuit are not in dispute. Because those price surveys, meetings and agreements on uniform fee schedules and fee increases are patently unreasonable on their face and are far more restrictive than necessary for any legitimate purpose of the defendant foundations, there is no genuine issue for trial. *United States v. Southern Motor Carriers Rate Conference, Inc.*, 467 F. Supp. at 486-87; *Kapp v. National Football League*, 390 F. Supp. at 82. *See National Society of Professional Engineers v. United States* 435 U.S. 679, 98 S.Ct. at 1362-68 (affirming lower

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court decision based on *per se* analysis and holding it was not error for district court not to make finding on defendant's assertion that competition would lead to inferior engineering work).

> Summary judgment for violations of the antitrust laws is proper where less restrictive means than those used could have been employed. *International Salt Co. v. United States*, 332 U.S. 392, 397-398, 68 S.Ct. 12 (1947)

In *Associated Press v. United States*, 326 U.S. 1, 65 S.Ct. 1416 (1945), the Supreme Court upheld a district court's order granting summary judgment and permanent injunctive relief for the government against enforcement of the Associated Press's restrictions on membership. *See* 52 F. Supp. 362. Engaging in a Rule of Reason analysis, the Supreme Court held the restraint at issue in that case to be unlawful and concluded that

> [T]here was no injury to any of the appellants as a result of summary proceedings since . . . the restrictive arrangements which appellants admitted, were sufficient to justify summary action by the court at that stage of the case. 326 U.S. at 6, 65 S.Ct. at 1418.

See also Silver v. New York Stock Exchange, 373 U.S. 341, 83 S.Ct. 1246 (1963).[14] Because the pleadings, depositions, admissions and affidavits on file in this matter show that there is no genuine issue as to any material fact, plaintiff is entitled to judgment under Rule 56(c), Federal Rules of Civil Procedure.

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[14] *Cf., Goldfarb v. Virginia State Bar*, 355 F. Supp. 491 (in bifurcated proceedings, issue of liability was determined on the basis of a one day hearing); *United States v. Utah Pharmaceutical Ass'n*, 201 F. Supp. at 30 (most of the material facts having been stipulated, trial of case required less than one day).

V

PLAINTIFF IS ENTITLED TO A PERMANENT INJUNCTION AGAINST DEFENDANTS' UNLAWFUL PRICE-FIXING ACTIVITIES

It is well-established that under section 16 of the Clayton Act, 15 U.S.C. § 26, injunctive relief is appropriate not only to avoid a recurrence of defendants' violations of the Sherman Act, but also to eliminate the anticompetitive consequences of defendants' conduct. *National Society of Professional Engineers v. United States*, 435 U.S. at 697, 98 S.Ct. at 1368; *International Salt Co. v. United States*, 332 U.S. 392, 400-401, 68 S.Ct. 12, 17 (1947); *United States v. Glaxo Groups, Ltd.*, 410 U.S. 52, 64, 93 S.Ct. 861, 868 (1973). Similarly, Arizona's Uniform State Antitrust Act provides for appropriate injunctive relief against violations of the Act. Ariz. Rev. Stat. Ann. § 44-1408. Having carried its burden of proving that defendants' conduct is in violation of the Sherman Act and the Uniform State Antitrust Act under both the Rule of Reason and the *per se* rule, plaintiff is entitled to permanent injunctive relief. *United States v. Southern Motor Carriers Rate Conference, Inc.*, 467 F. Supp. at 473, 487.

VI

IN THE ALTERNATIVE, THIS COURT SHOULD ENTER AN ORDER PURSUANT TO RULE 56(d), FEDERAL RULES OF CIVIL PROCEDURE, SPECIFYING THE ISSUES OF FACT AND LAW WHICH REMAIN TO BE TRIED IN THIS MATTER.

Should the Court not render summary judgment in plaintiff's favor, the preparation of this case for trial would be greatly assisted by the entry of an order pursuant to Rule 56(d), Federal Rules of Civil Procedure, specifying the facts that appear without substantial controversy and the issues of law and fact which remain to be tried. Plaintiff believes that, should its motions be denied, the motion for preliminary injunction which plaintiff filed in this matter on October 25, 1978 could be brought on for hearing within a

few weeks, and a trial on the merits held within a matter of months. There is, however, some uncertainty as to the issues of fact which would remain to be tried and the discovery which would be necessary for trial under a Rule of Reason standard. In the absence of summary judgment, an order specifying the issues of law and fact which remain to be tried at the order to show cause hearing and the trial on the merits and directing that the order to show cause hearing be held forthwith in accordance with Local Rule 42 would prevent unnecessary discovery and delay and expedite the resolution of the important issues raised by this lawsuit to the mutual benefit of all parties.

VII

CONCLUSION

WHEREFORE, plaintiff STATE OF ARIZONA respectfully requests that this Court enter its order:

1) granting plaintiff's motion for summary judgment and permanent injunction, or, alternatively,

2) specifying the facts that appear without substantial controversy and the issues of fact and law that remain to be tried and directing further proceedings in this matter including the hearing of plaintiff's motion for preliminary injunction.

DATED: July 6, 1979.

(signatures omitted in printing.)

Filed - JUL 6, 1979
W. J. Furstenau, Clerk
U. S. District Court
For The District of Arizona

(Caption omitted in printing.)

STATEMENT OF UNDISPUTED FACTS SUPPORTING PLAINTIFF'S MOTION FOR SUMMARY JUDGMENT AND PERMANENT INJUNCTION

Plaintiff STATE OF ARIZONA submits, pursuant to Rule 11(h), Rules of Practice of the United States District Court of the District of Arizona 1978, the following statement of undisputed material facts which support plaintiff's motion for summary judgment and permanent injunction. The following facts have been established by the business records and sworn testimony of the parties and certain witnesses, by Defendants' Responses to Plaintiff's First Request for Admissions and by public records. Defendants have stipulated that the documents which are attached as Exhibits to Plaintiff's First Request for Admissions are their business records. (Exhibit D to Statement of Undisputed Facts Supporting Plaintiff's Motion for Partial Summary Judgment on the Issue of Liability with Supplemental References.)

STATEMENT OF FACTS

1. Each of the defendants is an association of doctors. (Maricopa County Medical Society's Response to Plaintiff's First Request for Admissions hereinafter "Maricopa Society's Admissions") No. 309; Maricopa Foundation for Medical Care's Response to Plaintiff's First Request for Admissions, (hereinafter "Maricopa Foundation's Admissions" Nos. 310-311; Pima Foundation for Medical Care's Response to Plaintiff's First Request for Admissions (hereinafter "Pima Foundation's Admissions") No. 428. Defendants Responses to Plaintiff's First Request for Ad-

missions are found in the record as Exhibits A, B and C to the Statement of Undisputed Facts Supporting Plaintiff's Motion for Partial Summary Judgment on the Issue of Liability with Supplemental References.)

2. The defendant Societies have known and approved of the activities of the defendant foundations. (Maricopa Society's Admissions Nos. 198, 200-203, 222, 314; Exhibit MS-4 and MS-5 to Plaintiff's First Request for Admissions; Maricopa Foundation's Admissions Nos. 198-203, 222; Exhibits MF-52, MF-80, MF-119 to Plaintiff's First Request for Admission; Exhibits PF-134 and PF-139 to Plaintiff's First Request for Admission.)

3. The defendant societies founded the defendant foundations for the purpose of promoting the interests of fee-for-service medicine. (Maricopa Foundation's Admissions No. 91; Pima Foundation's Admissions No. 317; Exhibits MF-27, MF-79, MF-89, MF-90 and MF-95 to Plaintiff's First Request for Admissions.)

4. Defendants have repeatedly represented that their membership represents a substantial percentage of the fee-for-service physicians in their respective communities. (Maricopa Foundation Admissions Exhibit MS 1; Pima Foundation Admissions Exhibit PF-125; of Alice McClain dated July 5, 1979 attached as Exhibit C to this Statement).

5. The Board of Directors of defendant Maricopa County Medical Society (Hereinafter Maricopa Society) is elected by the membership of the Maricopa Society. (Maricopa Society's Admissions No. 2.)

6. The membership of defendant Maricopa Foundation for Medical Care hereinafter ("Maricopa Foundation") has included:

a. administrative members, who are the members of the Board of Directors of defendant Maricopa Society;

b. participating members, who belong or are qualified to belong to the Maricopa Society or any other county medical society in Arizona or the Arizona Osteopathic Society;

c. cooperating members who are members of the Arizona Podiatry Society or the Arizona Society of Oral Surgeons (Maricopa Foundation's Admissions No. 1. (Chapter II, Sections 1 through 7, By-Laws of Maricopa Foundation, Exhibit MF-122 to Maricopa Foundation's Admissions.)

7. The membership of defendant Maricopa Society is "limited to select physicians chosen by the Maricopa Society." (Maricopa County Medical Society's Articles of Incorporation, certified copy attached as Exhibit A to this Statement.)

8. The defendant societies are the local components of the Arizona Medical Association, which is in turn a component of the American Medical Association. (Articles of Incorporation of Arizona Medical Association certified copy attached as Exhibit A to this Statement).

9. The members of the Board of Directors of the defendant Maricopa Society automatically become administrative members of defendant Maricopa Foundation. (Maricopa Foundation's Admission No. 3.)

10. The administrative members of defendant Maricopa Foundation have elected by majority vote the Board of Trustees of the Maricopa Foundation. (Chapter XI, Section 1, By-Laws of Maricopa Foundation, Exhibit MF-122 to Plaintiff's First Request for Admissions; Maricopa Society's Admissions Nos. 5, 177, 245, 264, 267, 308; Maricopa Foundation's Admissions Nos. 177, 245, 264, 267, 308; Exhibits MS-1, MS-10 through MS-13 and MF-67 to Plaintiff's First

11. At least nine members of the Board of Trustees and all members of the Executive Committee of defendant Maricopa Foundation must be participating members of the Maricopa Foundation. (Chapter V, Section 2, and Chapter VI, Section 4, By-Laws of Maricopa Foundation, Exhibit MF-122 to Plaintiff's First Request for Admissions.)

12. Among the powers of the Trustees of defendant Maricopa Foundation is the power "to adopt and to propose to the participating membership uniform average or median fee schedules for medical services, which when adopted by a majority vote of the participating membership shall be binding upon all participating members[.]" (Chapter V, Section 2, By-Laws of Maricopa Foundation, Exhibit MF-122 to Plaintiff's First Request for Admissions.)

13. The voting power of participating and cooperating members of defendant Maricopa Foundation has been limited to the power "to vote on the adoption of any uniform average or median fee schedule for medical services by mail ballot." (Maricopa Foundation's Admissions No. 34, Exhibit MF 122 to Plaintiff's First Request for Admissions; Chapter II, Sections 5, 7, By-Laws of Maricopa Foundation.)

14. Applicants for participating membership in defendant Maricopa Foundation have been required to complete and sign an application blank which contains an agreement "to be bound by any and all rules, regulations, committee decisions, fee schedules, and the like, adopted by [the foundation]." (Chapter II, Section 9, By-Laws of Maricopa Foundation, Exhibit MF-122 to Plaintiff's First Request for Admissions.)

15. Defendant Maricopa Foundation has had a standing fee schedule committee. (Chapter X, Section 2, By-Laws of the Maricopa Foundation, Exhibit MF-122 to Plaintiffs First Request for Admissions.)

16. Defendant Pima County Medical hereinafter Pima Society Society severed its relationship with defendant Pima Foundation for Medical Care hereinafter ("Pima Foundation") in October, 1978, after the complaint in this action had been filed. (October, 1978 By-Laws of Pima Foundation, Exhibit N to Supplemental Rule 11(h) Statement on Liability.)

17. The membership of defendant Pima Foundation from its inception until October, 1978 included:

a. administrative members, who were the members of the Board of Directors of defendant Pima Society;

b. participating members, who belonged or were qualified to belong to the Pima Society or the county medical society in a county contiguous to Pima County;

c. cooperating members, who were members of the Arizona Osteopathic Society or the Arizona Podiatry Society who practiced in Pima County.

(Chapter II, Section 1, By-Laws of Pima Foundation, Ehibit PF-188 to Plaintiff's First Request for Admissions.)

18. The administrative members of defendant Pima Foundation from its inception until October, 1978, were elected by majority vote of the Board of Directors of defendant Pima Society. (Chapter XI, Section 1, By-Laws of Pima Foundation, Exhibit PF 183 to Plaintiff's First Request for Admissions; Pima Foundation's Admissions No. 416; Exhibits PS-7 through PS-33 to Plaintiff's First Request for Admissions.)

19. Until October, 1978, two-thirds of the Trustees of defendant Pima Foundation were required to be participating or cooperating members of the Pima Foundation. (Chapter VI, Section 4, By-Laws of Pima Foundation, Exhibit PF-183 to Plaintiff's First Request for Admissions.)

20. Among the powers of the Trustees of defendant Pima Foundation from its inception until October, 1978, was the power "to adopt and to propose to the Participating Membership uniform fee schedules for medical services, which when adopted by the majority vote of the Participating Membership [were] binding upon all Participating Members of [the Pima Foundation.]" (Chapter V, Section 2, By-Laws of Pima Foundation dated, Exhibit PF-183 to Plaintiff's First Request for Admissions.)

21. From the inception of defendant Pima Foundation until October, 1978, the voting power of its participating members was limited to "the power to vote on the adoption of any uniform fee schedule for medical services by the Foundation . . . by mail ballot." (Chapter II, Section 5, By-Laws of Pima Foundation, Exhibit PF-183 to Plaintiff's First Request for Admissions.)

22. Applicants for participating membership in defendant Pima Foundation from its inception until October, 1978, were required to complete and sign an application blank which contained an agreement "to be bound by any and all rules, regulations, committee decisions, fee schedules, and the like, adopted by [the Pima Foundation.]" (Chapter II, Section 9, By-Laws of Pima Foundation, Exhibit PF-183 to Plaintiff's First Request for Admissions.)

23. Defendant Pima Foundation has had a standing fee schedule committee. (Chapter X, Section 2, By-Laws of Pima Foundation, Exhibit PF-183 to Plaintiff's First Request for Admissions.)

24. Since October, 1978, defendant Pima Foundation has had one class of Corporate Members which is open to "any physician or podiatrist authorized [under Arizona law] to practice medicine in the State of Arizona who practices in

Pima County or a county contiguous to Pima County." (Chapter II, Section 2, October 1978 By-Laws of Pima Foundation, Exhibit N to Supplemental Rule 11(h) Statement on Liability.)

25. The Corporate Members of defendant Pima Foundation now elect by majority vote the Board of Trustees of that Foundation. (Chapter XI, Section 1, October 1978 By-Laws of Pima Foundation, Exhibit N to Supplemental Rule 11(h) Statement on Liability.)

26. Two-thirds of the Board of Trustees of defendant Pima Foundation must be Corporate Members of the Pima Foundation. (Chapter VI, Section 4, October 1978 By-Laws of Pima Foundation, Exhibit N to Supplemental Rule 11(h) Statement on Liability.)

27. Among the powers of the Trustees of defendant Pima Foundation is the power "to adopt and to propose to the Corporate Members contract limits for medical services, which when adopted by a majority vote of the Corporate Membership shall be binding upon all Corporate Members [.]" (Chapter V, Section 2, October 1978 By-Laws of Pima Foundation, Exhibit N to Supplemental Rule 11(h) Statement on Liability.)

28. The voting power of Corporate Members of defendant Pima Foundation is limited to "the right to vote on the adoption of any contract limits for medical services by the [Pima] Foundation." (Chapter II, Section 3, October 1978 By-Laws of Pima Foundation, Exhibit N to Supplemental Rule 11(h) Statement on Liability.)

29. The adoption of any "schedule for medical services" by the Corporate Members of defendant Pima Foundation is required to be "by mail ballot." (Chapter II, Section 3, October 1978 By-Laws of Pima Foundation, Exhibit N to Supplemental Rule 11(h) Statement on Liability.)

30. Applicants for Corporate Membership in defendant Pima Foundation must complete and sign an application blank which contains an agreement "to be bound by any and all rules, regulations, committee decisions, contract limits, and the like, adopted by [the Pima Foundation]." (Chapter II, Section 5, October 1978 By-Laws of Pima Foundation, Exhibit N to Supplemental Rule 11(h) Statement on Liability.)

31. Over one thousand (1,000) medical doctors who reside in Maricopa County, Arizona, are participating members of defendant Maricopa Foundation. (Maricopa Foundation's Admission No. 268; Exhibits MF-51, MF-64 (§ I, ¶10); and MF-112 through MF-118 to Plaintiff's First Request for Admissions.)

32. Over four hundred (400) doctors who reside in Pima County, Arizona, are participating members of defendant Pima Foundation. (Affidavit of Thomas P. Finley attached to Pima Foundation's Opposition [hereinafter "Finley Affidavit"] ¶7, Opposition of Defendant Pima Foundation to Plaintiff's Motion for Partial Summary Judgment on the Issue of Subject Matter Jurisdiction (hereinafter "Pima Foundation's Opposition"), at 14; Gerdenics Deposition, at 27-28 and Exhibits 6, 45, 46, 48 § 1, ¶8; Exhibit PF-125 to Plaintiff's First Request for Admissions.)

33. The participating and cooperating members of the defendant foundations have periodically executed applications for foundation membership. (Maricopa Foundation's Admissions No. 13, Gerdenics Deposition at 27, 28 and Exhibit 46; Exhibits PF-123 and MF-112 through MF-118 to Plaintiff's First Request for Admissions; Mitten Deposition, Vol. II, at 49-50 and Exhibit 55.)

34. Applications for participating and cooperating membership in the defendant foundations have contained an agreement that the foundation member will be bound by the foundation fee schedule. Maricopa Foundation's Admissions No. 14; Pima Foundation's Admissions No. 14; Exhibits PF-123 and MF-112 through MF-118 to Plaintiff's

First Request for Admissions; Gerdenics Deposition at 27-28 and Exhibit 46, ¶2; Mitten Deposition Exhibit 55, ¶5)

35. Defendant Maricopa Foundation has consistently maintained as members over 70 percent of the private practicing M.D.'s and approximately one-half of the osteopathic physicians in Maricopa County. (Exhibit A to McLain Affidavit Exhibit MS-51 to Plaintiff's First Request for Admissions.) 1979 Maricopa Foundation Bid to Department of Economic Security.

36. The defendant foundations have represented to their members and other doctors that the foundations have been working to protect the interest of doctors who practice on a fee-for-service basis. (Maricopa Foundation Admissions No. 91; Pima Foundation Admissions No. 213.)

37. The defendant foundations have prepared and published fee schedules for doctor's services. (Maricopa Foundation Admissions Nos. 44, 54, 250, 57, 58, 169, 176; Pima Foundation Admissions Nos. 57, 58, 346, 350, 356, 365-368, 375, 402, 409.)

38. The defendant foundations have proposed fee schedules to their members for approval by mail ballot. (Maricopa Foundation's Admissions Nos. 34, 36, 156-158, 164, 234, 235; Pima Foundation's Admissions Nos. 34, 347, 348, 362, 363, 402, 409, 412, 423, 425; Deposition of Anthony Mitten (hereinafter "Mitten Deposition" Vol. I at 114-118, Vol. II at 10-11.)

39. Defendant Pima Foundation has adopted fee schedules by mail ballot of its participating and cooperating members on at least the following occasions:

1. Jan. 1974
2. May 1976
3. Oct. 1976
4. Dec. 1977

(Pima Foundation's Admissions Nos. 34, 347, 348, 362, 363, 402, 403, 409, 412, 423, 425; Exhibits MF-1, MF-70, MF-88, MF-93, MF-95, MF-102 to Plaintiff's First Request for Admissions.)

40. Defendant Maricopa foundation has adopted fee schedules by mail ballot of its participating and cooperating members on at least the following occasions:

1. July 1974
2. Oct. 1975
3. Autumn, 1977

(Maricopa Foundation's Admissions Nos. 34, 36, 64, 156-158, 234, 235; Exhibits MF-1, MF-70, MF-88, MF-93, MF-95, MF-102 to Plaintiff's First Request for Admissions.)

41. The defendant foundations have referred to the fee schedules adopted by their members as "uniform fee schedules." (Chapter II, Section 5, By-Laws of Maricopa Foundation, Exhibit MF-122 to Plaintiff's First Request for Admissions; Chapter II, Section 5, By-Laws of Pima Foundation, Exhibit PF-183 to Plaintiff's First Request for Admissions;)

42. Defendant Maricopa Foundation has indicated in communications to their members and various groups of doctors that the foundation fee schedule should approximate the majority of doctors' charges. (Exhibits MF-3, MF-27 through MF-46 to Plaintiff's First Request for Admissions.)

43. The defendant foundations have made and entered agreements with certain insurers and other third parties that require the insurers and other third parties to pay for doctors' services to persons insured under foundation-approved plans at the prices set by the foundation fee schedules. (Maricopa Foundation's Admissions Nos. 10, 11, 12; Pima Foundation's Admissions Nos. 10, 11, 12; Gerdenics Deposition at 22-24, 110-112, Exhibits 5, 6, 48; Affidavit of Roger Beck, Exhibit A to Statement of Undisputed Facts Supporting Plaintiff's Motion for Partial Summary Judg-

ment on the Issue of Subject Matter Jurisdiction (hereinafter Rule 11(h) Statement on Subject Matter Jurisdiction) (hereinafter "Beck Affidavit"), Exhibits A-2, A-3, A-4 and A-9; Affidavit of William A. DeWaal, Exhibit B to Rule 11(h) Statement on Subject Matter Jurisdiction (hereinafter "DeWaal Affidavit"), Exhibits B-1, B-2, B-14, B-15, B-18, B-19 and B-29; Mitten Deposition, Vol. I at 21-23, Exhibit 13.)

44. Defendant foundations have endorsed or approved certain health insurance plans which are underwritten by private insurers and other third parties and meet certain "minimum standards" formulated by the defendant foundations. (Beck Affidavit Exhibits A-3, A-4, A-5 and A-9; DeWaal Affidavit Exhibits B-6, B-14, B-17, B-26 and B-27; Gerdenics Deposition at 27-28.)

45. The minimum standards for the defendant foundations include, among other things, the maximum allowable rate of payment set by the foundation fee schedules for covered doctors' services to persons insured under foundation-approved plans. (Maricopa Foundations Admissions No. 10; Pima Foundation's Admissions No. 10.)

46. The minimum standards of the defendant foundations require the insurer or other third party that underwrites a foundation-approved plan to pay 100 percent of the fees charged by doctors up to the maximum amounts set by the foundation fee schedules for doctors' services covered under the plan. (Maricopa Foundation's Admissions Nos. 14, 16; Pima Foundation's Admissions Nos. 14, 16.)

47. Defendant foundations have expressly limited the "professional payments" made under foundation-approved plans to "duly-licensed:

(a) Physicians and Surgeons (Doctors of Medicine);
(b) Doctors of Dentistry;
(c) Physicians and Surgeons (Doctors of Osteopathy); and

(d) Doctors of Chiropody (Podiatrists)."

(¶5 of Exhibits PF-108 and PF-118 to Plaintiff's First Request for Admissions; § I ¶7 of Exhibits MF-64 and MF-101 to Plaintiff's First Request for Admissions.)

48. The maximum doctors' fees allowed by the foundation fee schedules are determined by the defendant foundations in concert with their members, not by the insurers and other third parties that pay for doctors' services to persons insured under foundation-approved plans. (Maricopa Foundation's Admissions Nos. 10, 11, 12; Pima Foundation's Admissions Nos. 10, 11, 12; Mitten Deposition Vol. I pp 21-23.)

49. To determine the price allowed for a doctor's service under a foundation fee schedule, one must refer to both a relative value schedule and a unit conversion factor. (Maricopa Foundation's Admissions No. 17; Pima Foundation's Admissions No. 17.)

50. Defendants and their members have agreed upon, used, revised, published and circulated relative value schedules prepared by the California Medical Association, the American College of Radiology and the American Society of Anesthesiologists. (Maricopa Foundation's Admissions Nos. 19, 21, 23, 160; Pima Foundation's Admissions Nos. 19, 21, 23, 38, 323; Gerdenics Deposition, at 41-49, 82-26, Exhibit 18; Mitten Deposition, Vol. I at 71-82, Vol. II at 97-100; *see* Exhibits E, F, G, and H.) (to Statement of Undisputed Facts Supporting Plaintiff's Motion for Partial Summary Judgment on the Issue of Liability hereinafter Supplemental Rule (h) Statement on Liability.")

51. Pursuant to consent orders to cease and desist in the cases styled *In re California Medical Association*, FTC File No. 781005 (FTC, filed November 14, 1977), and *In re The American College of Radiology*, FTC File No. 7610059 (FTC, filed September 13, 1977 the California Medical Association and the American College of Radiology have been enjoined from initiating, developing publishing, circu-

lating or advising the use of any actual or proposed relative value schedule or conversion factor and have been ordered to cancel, repeal, abrogate and withdraw any and all relative value schedules which they have previously developed, published or circulated. (California Medical Association Agreement containing Consent Order to Cease and Desist attached to this Statement as Exhibit C; American College of Radiology, Agreement containing Consent Order to Cease and Desist attached to this Statement as Exhibit D.)

52. A relative value schedule is a list or compilation of doctors' services which assigns a comparative unit value to each service listed. (Maricopa Foundation's Admissions No. 17, 18; Pima Foundation's Admissions Nos. 17, 18; Exhibits E, F, G, and H to Supplemental Rule 11(h) Statement on Liability; Gerdenics Deposition at 25, 41-49, Exhibit 18; Mitten Deposition, Vol. I at 70-96.)

53. A unit conversion factor is a number or dollar figure used to multiply the unit value found in a relative value schedule for any doctor's service into a dollar figure payable for that service. (Maricopa Foundation's Admissions No. 160; Exhibit MF-102 to Plaintiff's First Request for Admissions; Mitten Deposition, Vol. I at 96-100, Exhibit 28; Gerdenics Deposition at 28, 44.)

54. Foundation fee schedules provide unit conversion factors to be used with certain relative value schedules to determine the amounts to be paid to doctors for services, goods and products sold by doctors. (Maricopa Foundation's Admissions Nos. 93, 94, 95, 96, 229, 233, 304; Pima Foundation's Admissions Nos. 344, 349, 364, 413, 426; Exhibits PF-1, PF-146, MF-63 and MF-121 to Plaintiff's First Request for Admissions; Gerdenics Deposition, Exhibits 20, 25, 26, 27, 28 29; Mitten Deposition, Vol. I at 96-104, Exhibit 2.)

55. An increase in the relative value assigned to a specific procedure in the relative schedules adopted by the defendant foundations increases the resulting price for that procedure; an increase in the foundation conversion factor

for any category of medicine increases the resulting prices for all the doctors' services included in that medical category in the relative value schedules adopted by the defendant foundations. Gerdenics Deposition at 24-26, 41-49.

56. Defendant Maricopa Foundation has published a conversion manual to facilitate the use of foundation conversion factors with different relative value schedules. (Exhibit H to Supplemental Rule 11(h) Statement on Liability.)

57. In concert with their members and various groups of doctors, the defendant foundations have agreed upon, published, circulated and encouraged the use of the relative value schedules adopted by their members. (Maricopa Society's Admissions No. 197; Maricopa Foundation's Admissions Nos. 28, 32, 122, 136, 137, 139, 193, 248, 261, 262, 263, 283; Pima Foundation's Admissions Nos. 28, 32, 318, 319, 321-323, 326, 328, 329, 330, 331, 332, 333, 334, 335, 336, 399, 410, 414, 424; Mitten Deposition Vol. I at 73-84, 95-96.)

58. In concert with their members and various groups of doctors, the defendant foundations have adjusted the unit values assigned to various doctors' services in the relative value schedules adopted by their members as a means of adjusting the prices to be paid to doctors for services to persons insured under foundation-approved plans. (Maricopa Society's Admissions No. 197; Maricopa Foundation's Admissions Nos. 28, 32, 122, 136, 137, 139, 193, 248, 261, 262, 263, 283, 296; Mitten Deposition, Vol. I at 73-84, 95-96, Vol. II at 97-100, Exhibits 56, 65, 66; Pima Foundation's Admissions Nos. 28, 32, 318, 319, 321, 322, 323, 326, 328, 329, 330, 331, 332, 333, 334, 335, 336, 399, 410, 414, 424; Gerdenics Deposition, at 84-86, Exhibit 48, § V; Exhibits PS-1, PF-1, PF-127 through PF-129, MF-47, MF-64, § V, MF-99, MF-100, MF-107 and MF-107A to Plaintiff's First Request for Admissions.)

59. The unit values assigned to certain doctors' services in the relative value schedules used by the defendant foundations have been revised and adjusted by defendants in cooperation with groups of doctors who specialize in those services. (Maricopa Foundation's Admissions Nos. 44, 45, 46, 47-49; Pima Foundations' Admissions Nos. 44-49, 50-54.)

60. The defendant foundations have consulted with their members and various doctors' associations concerning the preparation of Foundation fee schedules. (Maricopa Foundation's Admissions Nos. 44, 54, 250; Pima Foundation's Admissions Nos. 44, 54, 319-338; Exhibits MF-3, MF-4, and MF-62 to Plaintiff's First Request for Admissions; Mitten Deposition, Exhibits 59, 61, 66.)

61. The defendant foundations have consulted with various doctors' associations with respect to:

(a) the relative value schedules and unit conversion factors which their members use or prefer; and

(b) the relative value schedules and unit conversion factors which their members consider appropriate for foundation fee schedules.

(Maricopa Foundation's Admissions Nos. 44, 54, 104, 105, 106, 107, 112, 113, 114, 122, 126, 134, 135, 137, 166, 167, 179, 183, 193, 237, 238, 255, 252, 253, 258, 260, 261, 262, 263, 283, 284, 285, 287, 290, 291, 292, 293, 295, 296; Mitten Deposition, Vol. I, at 96, Pima Foundation's Admissions Nos. 44, 54, 319, 320, 321, 322, 323, 326, 328, 329, 330, 331, 332, 333, 334, 335, 336, 360, 414; Exhibits PF-109, PF-113, PF-169 through PF-182, PF-184 through PF-194, MF-57, MF-58, MF-60, MF-65 through MF-67, MF-77, MF-81, MF-99, MF-100, MF-103 and MF-104 to Plaintiff's First Request for Admissions.)

62. Defendants have asked other associations of doctors to meet and agree on the fees and fee schedules to be used by their members and to report the results of their agree-

ments to the defendants. (Maricopa Foundation's Admissions Nos. 44, 54, 250; MF-47; Pima Foundation's Admissions Nos. 44, 54, 319-338; Exhibits MF-4, PF-109 to Plaintiff's First Request for Admissions.)

63. Defendant Maricopa Foundation has polled its members on the fees they usually charge for their services. (Maricopa Society's Admissions Nos. 60, 101-103, 117, 172, 173, 197; Maricopa Foundation's Admissions Nos. 57, 58, 169, 176.)

64. Defendant Maricopa Foundation has polled various doctors' associations concerning the relative value schedules and unit conversion factors which their members considered appropriate for future foundation fee schedules. (*See, e.g.*, Exhibits MF-6 through MF-19 and MF-27 through MF-47 to Plaintiff's First Request for Admissions; Maricopa Foundation's Admissions Nos. 44, 54, 123, 124, 130, 160, 256, 261, 269, 279, 281, 284, 285, 286, 287, 290, 291, 292, 293, 295, 300; Mitten Deposition, Vol. II, at 87-88, Exhibits 59, 61.)

65. Foundation fee schedules have been published and circulated to doctors throughout the State of Arizona after their adoption by the members of defendant foundations. Maricopa Society's Admissions Nos. 60, 101, 102, 103, 117, 172, 197; Maricopa Foundation's Admissions Nos. 57, 58, 169, 176; Pima Foundation's Admissions Nos. 356, 365, 366, 368, 375, 402, 409.)

66. Foundation fee schedules have been published in the regular publications of the defendant societies. (Maricopa Society's Admissions Nos. 60, 101, 102, 103, 117, 172, 173, 197; (Maricopa Foundation's Admissions Nos. 57, 58, 169, 176; Pima Foundation's Admissions Nos. 57, 58, 346, 350, 356, 365, 366, 368, 375, 402, 209; Exhibits PS-1 and MS-14 to Plaintiff's First Request for Admissions; Affidavit of Anthony D. Mitten dated December 11, 1978, ¶2.)

67. The defendant foundations have mailed copies of their fee schedules to their members. (PS-1, MS-14, MSFRA's 60, 101, 102, 103, 117, 172, 173, 197; MFFRA-57, 58, 169, 176; AFFRD 356, 365, 366, 368, 375, 402, 409.)

68. The defendant foundations have mailed copies of their fee schedules to doctors who were not their members with applications for foundation membership. (PS-1, MS-14, MSFRA's 60, 101, 102, 103, 117, 172, 173, 197; MFFRA-57, 58, 169, 176; AFFRD 356, 365, 366, 368, 375, 402, 409.)

69. Fee schedules established by the membership of defendant Maricopa Foundation have been distributed upon request to possible applicants to the Maricopa Foundation.

70. Foundation members have agreed to accept the payment allowed by the Foundation fee schedule as full compensation on assigned claims of Foundation policyholders. (Maricopa Foundation's Admissions No. 14; Pima Foundation's Admissions No. 14; Mitten Deposition, Vol. I, p. 110; Affidavit of Anthony D. Mitten dated November 17, 1978, ¶4; Exhibits PF-123, MF-112 through MF-118, MF-64, § 1, ¶10, to Plaintiff's First Request for Admissions; Gerdenics Deposition Exhibit 48, § 1, ¶3; Finley Affidavit ¶16; Pima Foundation's Opposition, at 3 ("[The Pima Foundation] sets maximum rates for various categories of covered health services.")

71. Foundation conversion factors have on occasion been set higher than average and median doctors' prices at the time of their adoption. (Maricopa Foundation's Admissions Nos. 227 through 234, 269, 276; Mitten Deposition, Vol. II at 92-94.)

72. Fee data collected by the Health Insurance Association of America and the Arizona Medical Association in 1975 and 1976 showed the median and average fees charged by doctors in Arizona during that period remained at the approximate level set by the foundation fee schedule. When the foundation conversion factors were increased, the median and average fees increased to the new level set by the

foundation fee schedule. (Maricopa Foundation Admisions Nos. 228-235 Exhibit MF-71 to First Request for Admissions.)

73. Defendant Maricopa Foundation has sent defendant Pima foundation copies of fee schedules adopted by the Maricopa Foundation, and the Pima Foundation has subsequently adopted those fee schedules. (Maricopa Foundation's Admissions Nos. 63, 170, 171, 186; Pima Foundation's Admissions Nos. 63, 358, 359, 361, 362; Gerdenics Deposition at 60; Mitten Deposition, Vol. II at 47-48, Exhibit 53; Exhibits PF-132, PF-135, PF-151 and PF-154 to Plaintiff's First Request for Admissions.)

74. Doctors' prices have had a direct and substantial effect on payments made and premiums charged for health insurance in the State of Arizona. (Maricopa Foundation's Admissions Nos. 143, 224; Mitten Deposition, Vol. I at 60-64. Vol. II at 6-10, Exhibits 20, 21, 32, 33; Finley Affidavit ¶21 DeWaal Affidavit Exhibits B-2 through B-7, B-9, B-16 and B-17.)

75. The defendant foundations have provided advance notice of expected increases in foundation fee schedules to the insurers and other third parties that underwrite foundation-approved plans. (Maricopa Foundation's Admissions Nos. 61, 155, 163, 220, 223, 236; Mitten Deposition, Vol. I at 22-25, 51-62, Exhibits 14-18, 22, 59; Pima Foundation's Admissions No. 61; Exhibits MF-92, MF-96 and MF-98 to Plaintiff's First Request for Admissions; DeWaal Affidavit, Exhibit B-9.)

76. The prices set by the foundation fee schedules have had a direct and substantial effect upon payments made and premiums charged for foundation-approved plans. (Maricopa Society's Admissions Nos. 146, 147, 188; Mari-

copa Foundation's Admissions Nos. 143, 188, 224; *See* Finley Affidavit 21; DeWaal Affidavit, Exhibits B-2 through B-7, B-9 and B-17; Mitten Deposition, Vol. I at 60-64, Vol. II at 6-10, Exhibits 20, 21, 32, 33.)

77. Defendant Maricopa Foundation has employed insurance consultants to estimate the increases in premiums on fundation-endorsed health insurance plans which would result from increases in the foundation fee schedules adopted by the Maricopa Foundation's membership. (Maricopa Foundation's Admission No. 143.)

78. Defendant Maricopa Foundation discussed and approved increases in the deductibles on foundation-approved insurance plans to offset increases in permiums that would have otherwise resulted from increases in the foundation fee schedules adopted by the foundation's membership. (Mitten Deposition Vol. I Exhibit 21 at 63-64).

79. In the year 1966, the State of Arizona paid approximately $75,867,000.00 to doctors in Arizona. (Plaintiff's Response to Maricopa Foundation's First Set of Interrogatories No. 9(A)).

80. In 1975, the State of Arizona paid approximately $280,279,000.00 to Arizona doctors, almost triple the amount it paid in 1966. (Plaintiff's Response to Maricopa Foundation's First Set of Interrogatories to No. 9).

81. The State of Arizona Division of Finance pays approximately 7.6 million dollars per year for health insurance premiums. (Plaintiff's Response to Maricopa Foundation's First Set of Interrogatories to No. 9).

82. In 1977, the State of Arizona paid the following amounts for health insurance premiums: approximately $5,877,000.00 paid to Blue Cross/Blue Shield of Arizona for coverage provided through Pima Care, ABC-HMO, and Blue Cross and Blue Shield Programs; approximately $1,332,500.00 paid to Connecticut General Insurance Company, Hartford, Connecticut, for coverage provided through the Arizona Health Plan; approximately $401,100.00

paid to Pacific Mutual Life Insurance Company, Newport Beach, California for coverage provided through a Maricopa Foundation-approved Plan. (Plaintiff's Supplementary Response to Interrogatory No. 3(A) of Maricopa Foundation's First Set of Interrogatories.)

83. Defendant Maricopa Foundation has provided administrative and peer review services for at least one health care program without setting the doctors' fees payable under that program. (Exhibit E-1 to McLain Affadivit.)

DATED: July 6, 1979.

(Signatures omitted in printing.)

EXHIBIT A

(Certificate of Incorporation omitted in printing.)

ARTICLES OF INCORPORATION
OF
THE ARIZONA MEDICAL ASSOCIATION, INC.

KNOW ALL MEN BY THESE PRESENTS:

That the undersigned, whose residences and post office addresses appear opposite their respective names, have this day associated themselves together for the purpose of forming a non-profit corporation under the laws of the State of Arizona and do hereby adopt the following Articles of Incorporation.

ARTICLE I

The name of this corporation is and shall be THE ARIZONA MEDICAL ASSOCIATION, INC.

ARTICLE II

The location of its principal place of business shall be at Phoenix, Arizona but it may establish other places of business and other offices at such other places within the State of Arizona as the Board of Directors may from time to time determine.

ARTICLE III

The objects, purposes and powers of this corporation and the general nature of the business it proposes to transact are:

(a) To bring into one organization the entire medical profession of the State of Arizona to promote the science and art of medicine; to promote and elevate the standards of medical ethics and medical education; to promote public health and in all instances and manners to operate as a

non-profit business league and scientific and educational organization for the above stated purposes; provided, however, that the corporation shall not in any manner carry on propaganda or otherwise attempt to influence legislation;

(b) To make gifts of real and personal property to corporations, trusts, community chests, funds or foundations created or organized in the United States or in any possession thereof or under the law of the United States or of any state or territory or of any possession of the United States organized and operated exclusively for charitable, scientific or educational purposes or for such business league purposes as shall be in furtherance of the aims of this corporation, no part of the net earnings of which inures to the benefit of any private shareholders or individual, and no substantial part of the activities of which is carrying on propaganda or otherwise attempting to influence legislation;

(c) To act as trustee of trust funds created solely for charitable, scientific or educational purposes or for such business league purposes as shall be in furtherance of the aims of this corporation;

(d) To buy, contract for, lease and in any other lawful ways acquire, take, hold, own and to sell, mortgage, lease and otherwise dispose of lands and all other kinds and classes of real property and rights and interests therein;

(e) To buy, contract for, lease and in any other lawful ways acquire, take, hold and own personal and mixed property of all kinds and to sell, mortgage, lease and otherwise dispose of the same;

(f) To buy, sell, hold, use, lease and deal in franchises, easements, licenses, privileges, patents, rights of way, trademarks and trade names;

(g) To borrow money and to issue bonds, debentures, notes and other evidences of indebtedness and obligations from time to time for any lawful corporate purpose and to mortgage, pledge and otherwise charge any or all of its properties, rights, privileges and assets to secure the payment thereof;

(h) To accept by gift, devise or bequest money, property or rights;

(i) To establish terms and conditions of membership in the corporation; and

(j) To do all and everything necessary, suitable and proper for the accomplishment of any of the purposes or attainment of any of the objects hereinbefore mentioned either alone or in association with other individuals, corporations or partnerships and including federal, state, county and municipal bodies and authorities and in general to do any and all things which a natural person could do or which now or hereafter may be authorized by law and in general to do and perform such acts and things and transact such business in connection with the foregoing objects not inconsistent with law in any part of the world.

ARTICLE IV

The time for the commencement of this corporation shall be the date of the filling of these Articles of Incorporation as required by law and the term of its corporate existence shall be twenty-five (25) years thereafter, with privilege of renewal as provided by law.

ARTICLE V

This corporation shall be a non-profit corporation and shall have no stock and no dividends or pecuniary profits shall be declared or paid to the members thereof or to any other private individual and all of its earnings shall be used to further the purposes of this corporation as hereinabove set forth.

ARTICLE VI

The members, officers and directors of the corporation shall not be individually liable for the corporation's debts or other liabilities and the private property of such individuals shall be exempt from any corporate debts or liabilities.

ARTICLE VII

The control and management of the affairs of this corporation shall be vested in a board of directors of not less than five nor more than twenty-five members and the names of those selected to serve beginning with the incorporation of this corporation and until their successors shall be chosen are:

Dr. Robert E. Hastings
Dr. Harry T. Southworth
Dr. H. D. Ketcherside
Dr. Frank J. Milloy
Dr. C. E. Yount, Jr.
Dr. Harry E. Thompson
Dr. Jesse D. Hamer
Dr. Thomas H. Bate
Dr. A. I. Podolsky
Dr. Walter Brazie
Dr. Herbert B. Potthoff
Dr. Preston T. Brown
Dr. Robert S. Flinn
Dr. Harold W. Kohl
Dr. Donald E. Nelson
Dr. Hugh C. Thompson

The above directors were elected at a meeting held in Phoenix, Arizona on the 3rd day of May, 1950.

The Board of Directors shall have the right to increase and decrease within the limits above set forth the number of directors of the corporation and shall have the right to fill any vacancy in the Board of Directors in the manner

provided in the By-Law. The Board of Directors shall have full power to adopt, alter and amend By-Laws and to make proper rules and regulations for the transaction or the affairs of the corporation.

ARTICLE VIII

There shall be such class or classes of membership as may be set forth and provided for in the By-Laws of this corporation together with such voting privileges and other privileges, obligations and rights as therein set forth.

ARTICLE IX

No member shall possess any property right in or to the property or assets of the corporation. In the event of the dissolution or winding up of the corporation, all assets not otherwise disposed of and not subject to any trust shall be given, granted and conveyed to the American Red Cross.

ARTICLE X

These Articles of Incorporation may be amended by the affirmative vote of a majority of the members present at a meeting called for that purpose, provided that in no event shall Article V hereof be altered or amended in any manner whatsoever; and, provided further, that notice of proposed amendment or amendments shall be given by written notice the directors at least ten (10) days prior to said meeting, and by a publication once a week for two (2) successive weeks prior to the meeting in a newspaper of general circulation in the county wherein these Articles of Incorporation were published. Amendments shall be signed and acknowledged by the president and attested by the Secretary of the corporation and shall be filed, recorded and published as articles of incorporation of private corporations are required to be; provided, however, that such publication can be dispensed with when each member signs a waiver notice.

ARTICLE XI

Hereafter, the Board of Directors shall be elected at the regular annual meeting of the members which shall be held alternately in Phoenix and Tucson, Arizona, beginning with Tucson, Arizona in the year 1951 on the first Sunday of April of each year.

Each director shall hold office for a term of three (3) years or for such shorter period as he may have been elected or until his successor shall have been elected and qualified. The terms of office of directors Robert E. Hastings, M.D., H. D. Ketcherside, M.D., Frank J. Milloy, M.D., C. E. Yount, Jr., M.D., Harry E. Thompson, M.D., Jesse D. Hamer, M.D., Robert S. Flinn, M.D., Hugh C. Thompson, M.D., Preston T. Brown, M.D., and Herbert B. Potthoff, M.D., shall expire at the time of the next annual meeting in 1951; the terms of directors Harry T. Southworth, M.D., Harold W. Kohl, M.D., Walter Brazie, M.D., and Thomas H. Bate, M.D., shall expire at the time of the annual meeting in 1952; and the terms of directors A.I. Podolsky, M.D., and Donald E. Nelson, M.D., shall expire at the time of the annual meeting in 1953.

The members shall elect from among themselves a President, a Secretary and a Treasurer, and such other officers as shall be designated by the members from time to time. The time and the place of electing said officers and the terms of their office shall be fixed by the By-Laws.

ARTICLE XII

The highest amount of indebtedness or liability, direct or contingent, to which this corporation may be subject at any one time shall be such amount or amounts as may be authorized by three-fourths (¾ths) of the votes cast with respect thereto at a lawfully held meeting of the members of the corporation and approved by the Arizona Corporation Commission.

ARTICLE XIII

This corporation does hereby appoint Edward Jacobson of Phoenix, Arizona, who has been a bona fide resident of the State of Arizona for at least three years, its lawful agent in and for the State of Arizona for and on behalf of said corporation to accept and acknowledge service of, and upon whom may be served, all necessary process or processes in any action, suit, or proceeding that may be had or brought against said corporation in any of the courts in said State of Arizona, such service of process or notice or the acceptance thereof by said agent endorsed thereon to have the same force and effect as if served upon the President and Secretary of said corporation.

The foregoing appointment may be revoked at any time by filing an appointment of a successor agent.

IN WITNESS WHEREOF, we, the undersigned, have hereunto signed our names this 16th day of June, 1950.

(Signatures omitted in printing.)

EXHIBIT C

Agreement Containing Consent Order to Cease and Desist, *In the Matter of California Medical Association*, FTC File No. 781 0005, November 17, 1977

(Contents omitted in printing.)

EXHIBIT D

Agreement Containing Consent Order to Cease and Desist, *In the Matter of The American College of Radiology*, FTC File No. 761 0059, September 13, 1976

(Contents omitted in printing.)

EXHIBIT E

(Caption omitted in printing.)

AFFIDAVIT OF ALICE McLAIN

(Jurat omitted in printing.)

ALICE McLAIN, being duly sworn under oath, deposes and says:

1. I am Administrator of the Comprehensive Medical and Dental Program for Foster Children of the State of Arizona, Department of Economic Security, and as such am authorized to make this affidavit. I make these statements on the basis of facts within my personal knowledge.

2. The attached exhibits are copies of documents which were made and received in the ordinary course of business of the Comprehensive Medical and Dental Program for Foster Children of the State of Arizona, Department of Economic Security. They have been maintained in the ordinary course of business in the files of the Department of Economic Security and copies have been provided to the Attorney General of Arizona.

(Signatures omitted in printing.)

MARICOPA FOUNDATION FOR MEDICAL CARE

May 13, 1979

Ms. Alice McLain
CMDP Administrator
Department of Economic Security
P. O. Box 6123-940C
Phoenix, Arizona 85005

RE: Comprehensive Medical/Dental Program For Foster Children

Dear Ms. McLain:

Enclosed is the proposal from the Maricopa Foundation for Medical Care to continue the administration of the medical program for the Arizona Foster Children.

We feel our proposal responds directly to all aspects of the request for proposal from the Department of Economic Security.

Please feel free to contact me if there are clarifications necessary or if additional information is required.

Sincerely,

/s/ ANTHONY D. MITTEN
Anthony D. Mitten
EXECUTIVE DIRECTOR

ADM/hg

enc.

PREAMBLE

The Maricopa Foundation For Medical Care hereby submits the following proposal to continue to act as fiscal intermediary in the administration of the Comprehensive Medical and Dental Program for Foster Children under the authority of the State of Arizona.

The purpose of the Foundation's establishment in 1969 was to assure quality care at a reasonable cost to the public. Since July of 1970, the Foundation has performed medical review over one-half million claims for ambulatory medical services. Over 250 licensed, private practicing physicians review claims incuding M.D.'s, D.O.'s, and Podiatrists. During the past year, in relationship to our present administration of the Foster Children Program, we have established review teams of psychologists and licensed dentists.

Since August, 1971, the Foundation has been performing a Certified Hospital Admission Program (CHAP). This program is an institutional (hospitals and extended care facilities) review for pre-certification and certification of necessity of hospitalization and concurrent review of length of stay. We are presently monitoring over 1,000 hospital admissions per month in 26 hospitals in Maricopa County utilizing nurse coordinators and physician advisors. This type of hospital admission certification program has substantial effects in reducing the number of hospital days used for the plans monitored by the Foundation. Our statistics in 1978 indicated that the Foundation programs with CHAP had:

1. 441.8 admissions per 1,000.

2. 78.5 days per 1,000.

We feel that the Foundation concept has demonstrated its ability to be cost-effective while maintaining the highest quality of medical care. Our association with the Medical Society gives us the necessary physician cooperation and

control to continue to offer the Foster Children Program an effective review system, not only for medical care but for all other aspects of the comprehensive medical and dental program for the Foster Children.

In the following pages, we will discuss the operation of the Foundation in general and some specific aspects of the past years administration by the Foundation of the Foster Children Program.

II. BACKGROUND

The Maricopa Foundation For Medical Care was incorporated in 1969 in initially enrolled 85% of the active private practicing physicians in Maricopa County as participating members. The Foundation is a non-profit professional association composed of licensed Doctors of Medicine, Osteopathy and Podiatry engaged in the practice of medicine or surgery. Membership is voluntary and open to all Doctors of Medicine, Osteopathy and Podiatry in the state.

There are approximately 1500 active practicing M.D.'s available to private patients and 250 Osteopathic physicians in Maricopa County. The Foundation has consistently maintained over 70% of the private practicing M.D.'s and approximately one-half of the Osteopathic physicans as members. The majority of the Podiatrists in Maricopa County also participate in the Foundation organization. A copy of the 1979 Foundation membership book (Exhibit #1) is provided annually to each family covered by a Foundation-endorsed health plan.

The Maricopa Foundation started with seven sponsored groups in 1970 covering over 10,000 people and presently sponsors over 48 groups covering an estimated 100,000 lives in Maricopa County. Over 90,000 people in Foundation-endorsed plans have included the Certified Hospital Admission Program (CHAP) as part of their coverage.

The Maricopa Foundation has also operated claims processing and peer review of medical ambulatory services since its inception. Every claim for medical services is reviewed by a private practicing physician. This review takes place daily at the Maricopa Foundation office and review physicians are drawn from a pool of over 250 Foundation and non-Foundation physicians. A system for challenging review decisions has been established and operating since the inception of the Foundation program. Peer review physicians are reimbursed at a rate of $60.00 per hour as are the CHAP medical advisors. Physicians are not reimbursed for committee meetings, Board meetings or other matters relating to peer review or CHAP. During the past year the Foundation has established a special committee for the Foster Children Program and has expended hundreds of man hours in developing quality-conscious and cost-effective review and procedures. A detailed review of the Foundation's activities in regards to the Foster Children Program will be provided in another section of this proposal.

The statistics concerning the operation of the Maricopa Foundation's claim processing aspect and peer review functions are enclosed (Exhibit #2). As can be seen by these statistics, a substantial proportion of all claims processed by the Foundation are adjusted. Our figures established that since inception of the Foundation, the adjustments to billed charges by physicians have saved Foundation-endorsed plan employees over $6,000,000.

Among the more than 48 groups currently sponsored by the Maricopa Foundation are Arizona's largest private employer, Motorola; the City of Phoenix, the City of Scottsdale, various school districts and other smaller private employers (Exhibit #3).

The Maricopa Foundation has instituted a computerized data collection system for CHAP which enables the reviewing physician to more closely monitor utilization of in-hospital services and cost of those services. We have also

developed computerized reporting for the Foster Children Program on a special basis and are currently reviewing the possibilities of integrating some computerization of the actual claims processing facility run by the Foundation.

CERTIFIED HOSPITAL ADMISSION PROGRAM (CHAP)

The Certified Hospital Admission Program is a prospective hospital utilization program combining pre-admission and concurrent peer review by physicians to determine medical necessity for hospital admission and length of stay. This system has been in operation in Maricopa County since June of 1971.

The Foundation's Certified Hospital Admission Program has received excellent cooperation from the hospitals in the Maricopa County area. Enclosed (Exhibit #4) is the Foundation's Declaration of Policy issued to hospitals in this locality which outlines the procedure followed by CHAP and the approval given to the program by the Phoenix Regional Hospital Council.

As will be noted in the material, the Foundation makes every effort to utilize the existing hospital utilization committees to assist them in the operation of the Certified Hospital Admission Program.

CHAP concepts evolved from growing Foundation experience with successful peer review and include the following characteristics:

- Active involvement of attending physicians
- Preadmission certification
- Feedback to participating physicians as to peer standards and norms
- Relevant information systems and diagnostics (abstracting system)

Dynamic involvement of attending physicians, who have primary responsibility for patient admissions, surgeries, and discharges, is integral to CHAP design. Prior to hospitalizing a CHAP patient, attending physicians submit to the

Foundation physician advisory staff, an application for pre-admission certification. An application may be denied on the grounds that care could more appropriately be provided on an outpatient basis, that a planned surgery is not considered medically necessary or that preparatory lab work has not been completed, when feasible, prior to hospitalization. "Denial" refers only to the fact that payment will not be made for unauthorized services; medical judgments are left to the discretion of the attending physician, who, however, has been apprised through the review process of contraindicative peer opinion.

In the event that pre-admission certification of payment is made, the case is assigned to a nurse coordinator who will perform several administrative functions on behalf of the physician advisor. Abstracting from the admission application and subsequently, the medical record, the nurse coordinator completes a document detailing in patient experience of each CHAP case. An initial length of day is certified as payable, in accord with regional norms based on diagnosis. A tentative discharge date is affixed to the patient's chart as a reminder to the attending physician that in order for health insurance benefits to be payable beyond the specified date, an extension request must be approved by the physician advisor.

Emergency Admissions. In case of emergency admissions a CHAP nurse coordinator will initiate the certification process on the hospital premises and review the chart. The admitting officer should notify the CHAP certification desk at the Foundation office of all emergency admissions as soon as possible.

If a patient should be in and out of the hospital over the weekend before a CHAP nurse is available, the *Foundation guarantees certification for that hospital stay.*

Business Office Relationship

To finalize the hospital copy of the Certification Form the nurse coordinator will need to retrieve the hospital copy from the business office on the day of or following discharge.

The nurse coordinator will finalize the Certification Form immediately if the actual stay is less or equal to the days certified.

The actual stay is more than the days certified and no extension was approved by a medical advisor the nurse coordinator will certify only total days approved. In the foregoing case excess days constitute the patient's own expense.

Patients who have Foundation-endorsed health insurance plans with the CHAP benefit are presumed to understand that in order to have insurance coverage of their hospitalization, Foundation certification is mandatory and that certification also concerns the length of their hospital stay.

Conduct on the Ward

When arriving on the hospital ward the CHAP nurse coordinator is instructed to:

1. Report to the head nurse (and/or the unit clerk for permission to use the chart.
2. Consult with the head nurse before visting any patient to make certain the patient is not occupied with treatment, etc.

Nurse coordinators are instructed to conduct patient visits with discretion as to the area of the hospital where the patient is admitted. They will not, for example, visit psychiatric patients or those in ICU or CCU. Visits are conducted in a manner which will not disturb the patient. The nurse coordinator does not participate in care at the bedside.

The nurse coordinator realizes that she must fit her activity into the work flow of the hospital and will do so, tactfully.

Admitting Office Relationship

Elective admissions are pre-certified before the admission date. Printed notice of pre-certification will be presented to the admitting office before the patient appears (24 hours in advance of date of admission). The *Hospital Certification Control Form* will indicate initial certification for a specified number of days.

The hospital copy will not be in its final form until the patient is discharged and should not be relied upon for billing purposes until it has been finalized (indicating the TOTAL DAYS CERTIFIED).

The Role of the Nurse Coordinator in the Hospital

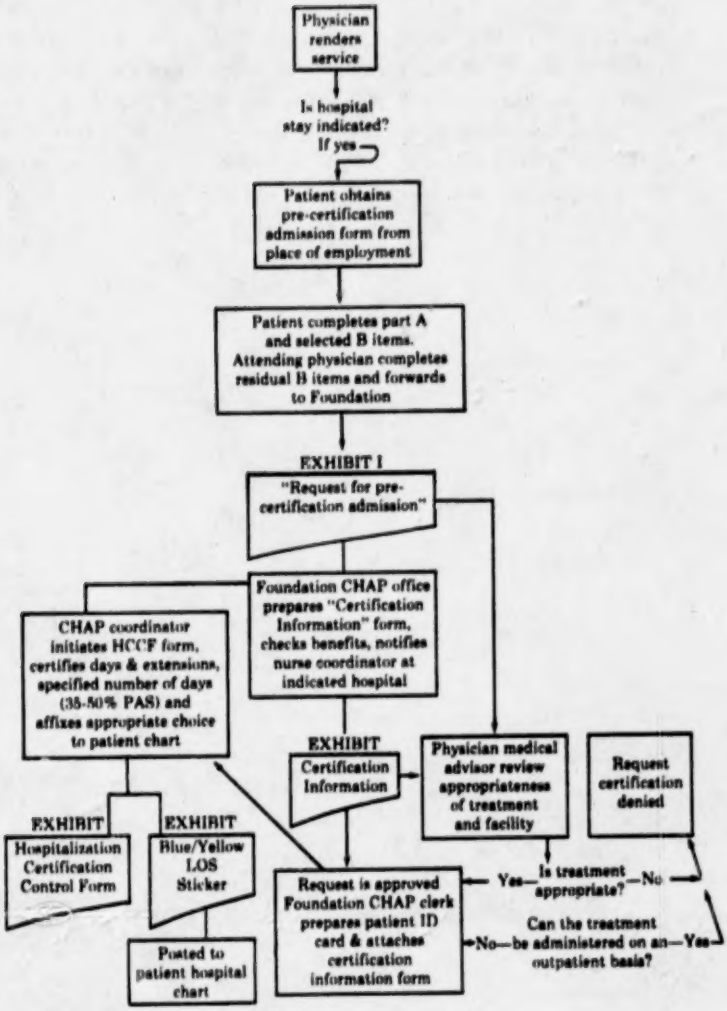
Both elective and emergency hospital admissions are certified. Initial certification is based upon statistical data found in the report of the *Commission on Professional and Hospital Activities* (1973 Regional PAS Study). Final certification is based upon each patient's personal progress, his unique medical need and individual nursing care requirement.

The CHAP nurse coordinator visits a CHAP insured patient during hospitalization to follow his progress and answer any questions the patient may have concerning insurance benefits.

In some instances the stated diagnosis may change, complications may be diagnosed or the surgery performed may be a different operation than was scheduled ... in these cases the nurse coordinator has documented reason to recode accordingly and amend the certification.

All extensions are determined by the *medical review physician team* in consultation with the attending physicians and not by the nurse coordinator.

The nurse coordinator visits the patient and reviews the chart on an on-going basis. Should an *extension* be requested by the attending physician she will have the information that the medical advisors may request for rendering an opinion of medical necessity for extension of hospital benefits. *No hospital benefits will be terminated without direct communication between the review physician and the attending physician.*


Physician renders service
Is hospital stay indicated? If yes
Patient obtains pre-certification admission form from place of employment
Patient completes part A and selected B items. Attending physician completes residual B items and forwards to Foundation
EXHIBIT I
"Request for pre-certification admission"
Foundation CHAP office prepares "Certification Information" form, checks benefits, notifies nurse coordinator at indicated hospital
CHAP coordinator initiates HCCF form, certifies days & extensions, specified number of days (35-50% PAS) and affixes appropriate choice to patient chart
EXHIBIT
Certification Information
Physician medical advisor review appropriateness of treatment and facility
Request certification denied
EXHIBIT
Hospitalization Certification Control Form
EXHIBIT
Blue/Yellow LOS Sticker
Posted to patient hospital chart
Request is approved Foundation CHAP clerk prepares patient ID card & attaches certification information form
Yes
Is treatment appropriate?
No
Can the treatment be administered on an outpatient basis?
No
Yes

This simple process is rarely adhered to in all its aspects and a myriad of complications may arise. The nurse coordinator makes the program work by keeping it responsive on a day-to-day basis to those mitigating circumstances which conspire to complicate the simple model.

The following diagram (Figure #1) illustrates the operation of CHAP. An outline of the activities of the CHAP nurse coordinator follows to indicate these duties in relation to the hospital. All decisions relating to the certification of hospitalization extension or denial of hospital days are made by the physician advisor.

AMBULATORY PEER REVIEW

As part of its administration of Foundation sponsored health insurance plans, the Foundation operates a system of professional review to insure the delivery of only appropriate, quality health care. Approximately 50 plans are now being reviewed, with 80,000 lives covered for both inpatient and ambulatory care.

Professional review procedures are closely coupled with claim processing activities, with particular attention paid to accurate coding. Claim data is entered onto manually maintained patient profiles used in the review process.

Review decisions are indicated on the claim and it is returned to the payment process.

The Foundation has developed broad guidelines of review criteria and made them available to its members so that they may fully comprehend the process of review (Exhibit #5).

Following is a brief outline of the history and purpose of peer review and an actual step by step procedure that the reviewing physician follows:

1. Initially a major peer review committee, comprised of various specialty representatives was established. In groups of two or three, this committee reviewed daily all of the claims submitted to the Foundation for payment.

2. As the committee became familiar with daily claim review an additional fifty physicians were integrated into the committee for the daily review. Two of the new physicians reviewing with one of the original physicians create a continuity that has worked well and evolved to establishing suggested guidelines as a common base to make the decisions somewhat consistent.

3. Copy of Suggested Guidelines was sent to each Foundation participating physician for his information.

4. A prerequisite for physicians serving on the Physicians Medical Review Committee is that they be in private practice, thereby being confronted with the same daily problems that are present in the practice of the physicians claims that he is reviewing. Therefore, each claim should be reviewed by a physician practicing in the same medical specialty field.

5. Our experience has shown that a reviewing physician is better able to relate a decision to the physician submitting the claim if communication is established by a telephone call rather than a written correspondence. Oral communication between the peer review committee and physician reviewed can not be over-emphasized as a means of better understanding and resolving problem areas.

Procedures for Reviewing Physicians

A. Purpose of Review: to answer these questions

1. Does the diagnosis given warrant the service rendered?

2. Do the service rendered warrant the fees charged?

B. Method of review: the following procedure is suggested

1. Scann the *COMPUTATION SHEET*. This sheet is attached to the inside cover of the family folder enables the reviewer to quickly familiarize himself with:
   a. Number of visits made by the patient.
   b. Services received by the patient.
   c. Previous medical expenses.
   d. Similar information for each member of the insured's family.

   Thus the computation sheet allows the reviewer to judge whether the patient or family might be thought to be overutilizing medical care and if so does this utilization involve one or several physicians.
2. Check the *PHYSICIAN REVIEW FORM*. This form furnishes information on the *claim* being reviewed.
   a. Diagnosis.
   b. Services rendered.
   c. Charges for services.
   d. Foundation's allowable charged for these services.

   From the Physician Review Form one can answer fundamental questions: Does diagnosis seem reasonable, does the diagnosis justify the services provided, do the charges seem reasonable?
3. Sign the *PHYSICIAN REVIEW FORM*. At this point you must do one of the following:
   a. Approve the claim for payment.
   b. Refer the claim to an appropriate specialist.
   c. Refer the claim to "team review".
   d. Refer to the Major Review Committee.
4. Check appropriate box if in your opinion there is suggestion of overutilization by patient or family or if there is over provision by the physician.

The following flow sheet demonstrates the operation of claims processing and physician peer review of ambulatory services (Figures 2 and 3).

FIGURE 2
CLAIMS PROCESSING

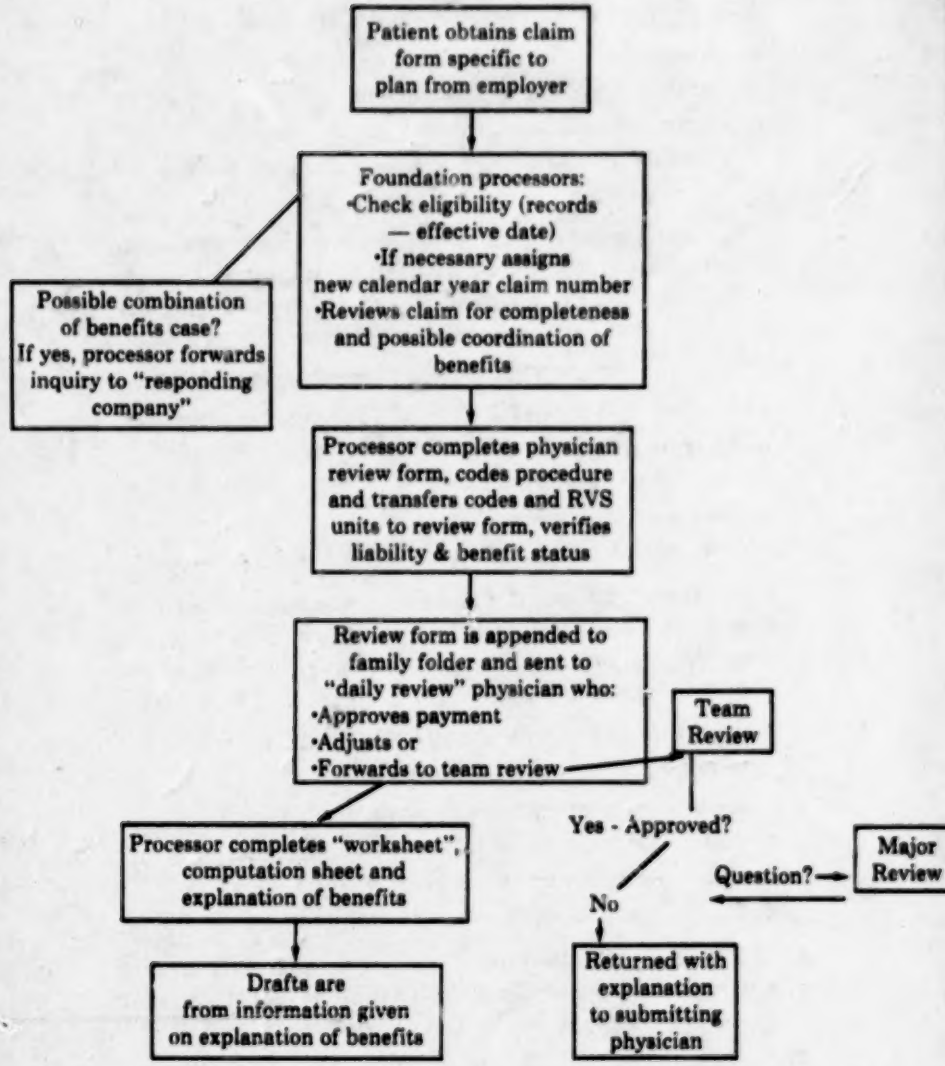
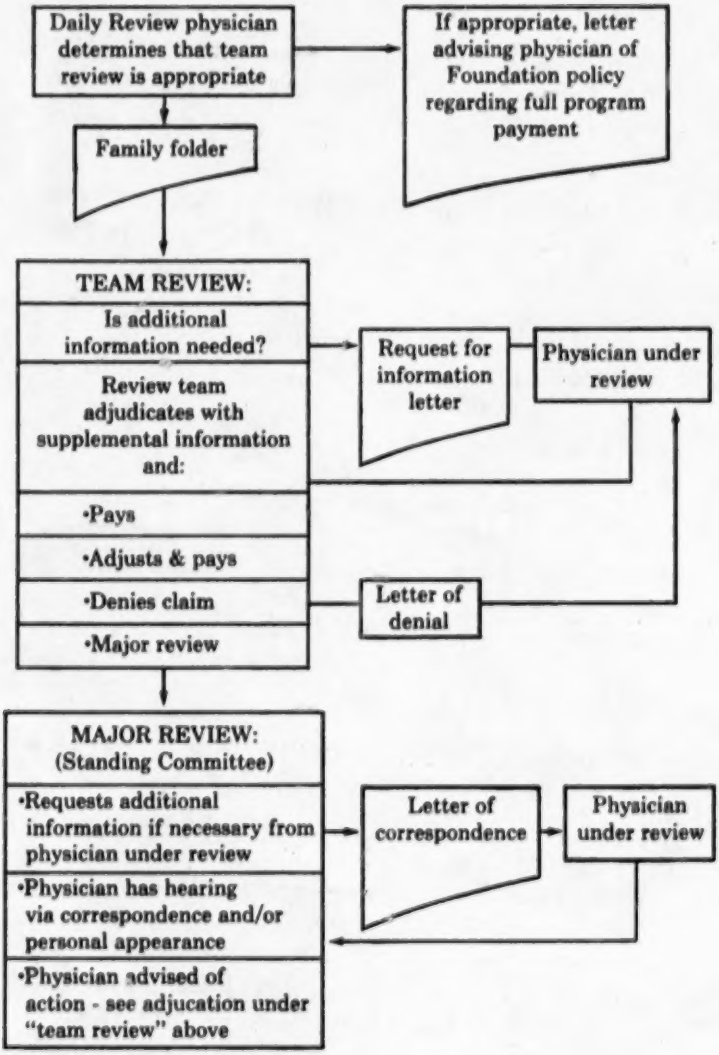


FIGURE 3
PHYSICIAN REVIEW



FOSTER CHILDREN PROGRAM - 1978-1979

The following is a brief review of the administration by the Foundation of the Foster Children Program since the award to the Foundation of this program, effective July 1, 1978. This is both an outline of our actions to date and a proposal to continue these procedures for the coming fiscal year.

PEER REVIEW-AMBULATORY CLAIMS-MEDICAL & SURGICAL SERVICES

In the review of medical and surgical services provided on an ambulatory basis, we feel that the regular Foundation's peer review would be, and has been, adequate insuring quality care and efficiency of cost. With modifications to indicate a prior authorization aspect of the Foster Children Program and the agreement of the provider to accept payment as payment in full, we have adopted the standard health insurance claim form for this program as well as the previously used prior authorization form for medical or surgical services. These forms are included in this proposal for review (Exhibit #6). As required by the program the authorization for medical equipment and/or supplies has been utilized as previously designed and is included as part of Exhibit #6.

PEER REVIEW-OUTPATIENT PSYCHIATRIC & PSYCHOLOGICAL SERVICES

As has been noted in the past, the history of the Foster Children Program indicates that a considerable proportion of the expenditures are for psychiatric or psychological treatments. This type of special problem has required an intensified effort on our part and has led to the development of a special prior authorization form, which was developed with the assistance of local psychiatrists, psychologists and other specialists. This new form (Exhibit #7) will permit a greater control of the program and provide considerably more data for continuing review.

PRIOR AUTHORIZATION-OUTPATIENT SERVICES

The medical and surgical review section of the Foundation has been expanded to include the requirement of prior authorization of the listed services as shown in the request for proposal from the Department of Economic Security. As indicated in the previous paragraph, the forms used by the Foundation for this are shown in Exhibit 6 and 7 and would be continued during the forthcoming year since they have proved to be effective in securing the information necessary to fulfill the statuatory requirements and to fulfill the needs of the medical reviewers involved.

CERTIFIED HOSPITAL ADMISSION PROGRAM (C.H.A.P.)

The CHAP concept has been outlined in detail in an earlier part of this proposal and has demonstrated its effectiveness over the years. This program pre-certifies the need for hospitalization and the length of stay for the procedure involved and fits in well with the statuatory requirements of the Foster Children Program. Prior authorization for elective surgery and concurrent review of this type of patient for the Foster Children Program has and will present no difficulty since the Foundation has performed these services for private groups throughout the state since 1971.

The prior authorization form, especially developed for psychiatric and psychological services lends itself to the special needs of this program on an inpatient basis also and will be continued to be used. In addition, the special Foster Children Committee has developed suggested criteria for hospitalization which have been approved by the Foundation Board and forwarded to the Department of Economic Security in March of this year (Exhibit #8). In addition, the Committee has implemented a recommended letter to all juvenile court judges recommending that the initial length of stay in court-ordered admissions be limited to 30 days. In reviewing the situations on court-ordered admis-

sions during the past few months it became apparent th some stays were ordered for periods over and above those medically necessary and it would seem more efficient to require shorter initial court-ordered admissions with continuation of the admission if medically necessary after review and discussion with the attending psychiatrist or psychologist. These recommendations, and others which will be forthcoming, are the results of many months work by the Committee and we are certain will prove to be beneficial to the program as times goes on.

DENTAL REVIEW-PRIOR AUTHORIZATION

The form previously used for prior authorization of dental treatment and as a statement for the dentist's actual services was adopted by the Foundation and is presently in use. During the past months, since the initiation of the Foster Children Program with the Foundation, we have established a comprehensive dental review program with the cooperation of the Central District Dental Society and have updated the dental criteria used for review. The Foundation has also met with the Pedodontists who are specialists in dental care of children and are looking forward to their special recommendations concerning coverage of dental care by the Foster Children Program. It is their recommendation that certain coverages be changed, which will be cost-effective, while maintaining quality of dental care necessary for those covered by this program. The pedodontists have been involved in the review process and we feel we have made significant strides in the dental aspects of this program.

SPECIAL NOTE

We feel that the Foundation has made significant strides in all aspects of review and administration of this program as required of a responsible fiscal intermediary employed

by the state. This is not to say that all problems involving the program have been solved but progress has been made and we feel that continuation of administration by the Foundation will be necessary if the progress is to continue.

We have had excellent cooperation from the Department of Economic Security personnel and from the providers of care, both institutional and individuals, throughout the state. The foregoing information responds to the request for proposal, (Exhibit #B) in regards to the medical evaluation system, the claims processing systems and the prior authorization procedures.

The Foundation will agree to make payment of the usual customary and reasonable costs of the covered service for the eligible foster children based upon the maximum allowable fee as scheduled by the Department of Economic Security as amended from time to time. We have maintained the current eligibility files as required and include as Exhibit #9 the description of the computerized system. Coordination of benefits section has been performed, as outlined in Exhibit B of the request for proposal, and we have provided the Department of Economic Security with an experienced employee for their staff to handle the portion of the coordination of benefits.

REPORTS

The Foundation has prepared the reports as required by the request for proposal and they are identical to the system requested in 1978. Included as Exhibit #10 is an outline of certain portions of these reports which are intended as examples of the type of reports provided and not as a complete listing of every report. We feel that our proposal conforms in every aspect to the Departments request for a proposal and look forward to continuing as fiscal administrator of this program.

BUSINESS PROPOSAL

The Foundation feels that a monthly charge of 13,900 will be necessary in order to provide the previously described services. We arrived at this figure based on our estimations of the number of personnel necessary to perform an adequate claims administration service and statistical reporting service plus the addition of peer reviewers as previously described. Out past years experience in this program has indicated certain areas which need to be increased in work load and we feel that this figure, which approximates 5.1% of the allocation for the program for fiscal 1979-1980 is most appropriate.

The following is a description of the type of personnel and the approximate cost to the Foundation for those services. We would be willing to sign a contract for the flat amount of $13,900 per month for the contract period and would be willing to abide by the figure provided there was no more than a 15% increase in the number of covered individuals during the contract year. If this figure of 15% were exceeded, the Foundation feels some reasonable adjustment would be necessary in the maximum monthly fee.

The personnel and costs at this state are as follows:

Coding Personnel — It is necessary that a uniform coding of claims be adopted and this is only possible with experience coding personnel to make certain the service provided is adequately described by the code. There may be adjustments necessary in the codes as submitted which require medical decisions and the Foundation is equipped by its experience and personnel makeup to provide the expertise. From the statistical information provided by the Department of Economic Security it is apparent that this group generates a higher number of claims than might be generated by a business firm of the same size.

$ 750.00

Claim Examiner/Reviewers — These are experienced claim processors who also work with the physician reviewer in doing the administrative work required of the claim in the processing aspect and following up to the conclusion the directions provided by the physician reviewer. In the Foundation model additional experience is necessary over and above a typical claims processor since the claim examiner in the Foundation model works as a team with the physician review panel.

$ 1,900.00

Clerical Personnel — The clerical functions of mail room activities, matching the claim with the files and forwarding the appropriate material to all parties concerned requires two clerks and filing personnel for this program.

$ 1,500.00

Data Analyzing and Reporting Personnel — These persons will analyze the claims to provide the information outlined in the Request for Proposal and any special information required of the current program by the Department of Economic Security. The Foundation has developed a computerized reporting system for the Foster Children Program even though we maintain the majority of our regular outpatient services on a manual statistical system. The input for the computerized system requires special personnel and these have been provided by the Foundation. We feel that the system as is presently constituted fulfills the peculiar needs of the Foster Children Program and has considerable additional information available if the need arises for that data.

$ 900.00

Data Reports — Required by D.E.S. — These particular reports were not included in the Request for Proposal last year and the Foundation's charges were

increased accordingly to provide this data to the Department of Economic Security. The charge includes systems support which is the design of the program and the hardware to implement the reports.

$ 1,000.00

Certified Hospital Admission Program — As mentioned earlier this program would run in the same manner as the present CHAP system and would employ nurse coordinators to administer the program in the hospital setting. Presently the Foundation has nurse coordinators who visit all the hospitals in this community. The number of coordinators would have to be increased in certain hospitals because of the increased work load and other arrangements would have to be made for hospitals outside of this community over and above the present arrangements which exist.

$ 2,400.00

Peer Review — The amount of reviewing time necessary to be provided by physicians and by other professionals such as dentists, podiatrists, psychologists, etc. would be approximately 50 hours per month. The Foundation presently compensates reviewers at a rate of $60.00 per hour.

$ 3,000.00

Administrative Support — The regular administrative support supplied to any group would be supplied to the Foster Children Program and it would include time provided by an assistant manager of claims, our Administrative Director and whatever additional administrative time provided by the Executive Director as necessary. This figure includes general office

overhead for a program of this size as well as all the preparation and printing of the special forms and booklets necessary for this program.

$ 2,450.00

Total $13,900.00

(Exhibits to Proposal deleted in printing.)

Remaining attachments omitted in printing.

EXHIBIT F

(Omitted in printing.)

Filed - JUL 6, 1979
W. J. Furstenau, Clerk
U. S. District Court
For The District of Arizona

(Caption omitted in printing.)

PLAINTIFF'S MOTION FOR RECONSIDERATION OF MEMORANDUM AND ORDER OF JUNE 5, 1979, OR, ALTERNATIVELY, MOTION FOR CERTIFICATION FOR INTERLOCUTORY APPEAL PURSUANT TO 28 U.S.C. § 1292(b) OF MEMORANDUM AND ORDER OF JUNE 5, 1979

In the event that this Court does not grant plaintiff's concurrent motion for summary judgment and permanent injunction, plaintiff STATE OF ARIZONA respectfully prays that this Court enter its order vacating the Memorandum and Order dated June 5, 1979 insofar as it denied plaintiff's motion for partial summary judgment on the issue of liability and that this Court grant plaintiff's motion for partial summary judgment on the issue of liability. Alternatively, plaintiff STATE OF ARIZONA respectfully prays that this Court enter its order pursuant to 28 U.S.C. § 1292(b) that insofar as it denied plaintiff's motion for partial summary judgment on the issue of liability the Memorandum and Order dated June 5, 1979 involves a controlling question of law as to which there is substantial ground for difference of opinion and that an immediate appeal from that portion of the order may materially advance the ultimate termination of the litigation. These motions are based on the entire record in this matter and the following memorandum of points and authorities.

MEMORANDUM OF POINTS AND AUTHORITIES

I.

THIS COURT'S DECISION IS CONTRARY TO THE WELL ESTABLISHED UNDERSTANDING OF THE RULE OF REASON AND THE *PER SE* RULE AS DEFINED BY THE UNITED STATES SUPREME COURT

Whatever may be said for or against the *per se* analysis of other antitrust violations, its application to horizontal price-fixing cases had never been seriously questioned until this Court's recent opinion. Since this Court's error is no doubt due to plaintiff's failure to explain the *per se* rule and its application, we take this opportunity to attempt to remedy our past deficiency.

The *per se* standard is an analytical subset of the Rule of Reason, not its counterpoint. As Justice Stevens recently explained:

> [P]roperly understood, rule of reason analysis is not distinct from "*per se*" analysis. On the contrary, agreements that are illegal *per se* are merely a species within the broad category of agreements that unreasonably restrain trade; less proof is required to establish their illegality, but they nonetheless violate the basic rule of reason. *United States v. United States Gypsum Co.*, 98 S.Ct. 2864, 2892 (1978) (footnote omitted) (Stevens J. concurring in part and dissenting in part.)

Development of a *per se* rule for certain violations of the Sherman Act began with Chief Justice White's seminal opinion in *Standard Oil Co. v. United States*, 221 U.S. 1,

31 S.Ct. 502 (1910).[1] Faced with the all-inclusive language of section 1 of the Sherman Act, which prohibited "[e]*very* contract, combination in the form of trust or otherwise, or conspiracy, in restraint of trade or commerce," 15 U.S.C. § 1 (emphasis supplied), and was "broad enough to embrace every conceivable contract or combination which would be made concerning trade or commerce," the Chief Justice reasoned that the statute "contemplat[ed] and requir[ed] a standard." 221 U.S. at 60, 31 S.Ct. at 516. The standard which the Supreme Court adopted for Sherman Act analysis was the standard of reason which had been applied at the common law and in this country in dealing with [restraints of trade]." *Id.*

In canvassing the legal standards which had been applied to restraints of trade, Chief Justice White determined that certain restraints which had the effect of leading towards the evils of monoply had been consistently barred by the courts. Those restraints included:

(1) the power . . . to fix the price and thereby injure the public;

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[1] Judge (later Chief Justice) Taft's opinion in *United States v. Addyston Pipe & Steel Co.*, 85 F. 271 (6th Cir. 1898), *aff'd*, 175 U.S. 211, 20 S.Ct. 96 (1899), complements Chief Justice White's opinion in *Standard Oil*. In *Addyston*, the court ruled that an agreement by members of an association of cast iron pipe manufacturers to eliminate competition among themselves was invalid under the Sherman Act because the agreement was not ancillary to any legitimate purpose. Under the "ancillary purpose" doctrine, a contract which had an effect of restraining trade might still be sustained if that part of the contract which restrained trade was ancillary or necessary to the achievement of a legitimate aim of the contract. 85 F. at 282-83. For example, a contract for the sale of a business might reasonably restrict the ability of the seller to compete with the buyer because the restrictive covenant is a means "of securing the seller against an increase of competition of his own creating [and is] necessary to promote the free purchase and sale of property." *Id.* at 281. *See Mitchel v. Reynolds*, 1 P. Wms. 181, 24 Eng. Rep. 347 (1711) (upholding as reasonable a restrictive covenant in the sale of a business).

(2) the power ... of enabling a limitation on production; and
(3) the danger of deterioration in quality of the monopolized article .... *Id.* at 52, 31 S.Ct. at 512.

The "contracts" and "other acts" which Chief Justice White said produced those evils and therefore offended the Sherman Act were defined by the Chief Justice as *"all* contracts or acts which were unreasonably restrictive of competitive conditions." *Id.* at 58, 31 S.Ct. at 515.

Under the Rule of Reason standard which the Supreme Court has followed since the Standard Oil decision, unreasonableness can be based "either (1) on the nature or character of the contracts, or (2) on surrounding circumstances giving rise to the inference or presumption that they were intended to restrain trade and enhance prices." *National Society of Professional Engineers v. United States*, 435 U.S. 679, 690, 98 S.Ct. 1355, 1364 (1978), *citing Standard Oil.*

> In the first category are agreements whose nature and necessary effect are so plainly anticompetitive that no elaborate study of the industry is needed to establish their illegality - they are "illegal per se" in the second category are agreements whose competitive effect can only be evaluated by analyzing the facts peculiar to the business, the history of the restraint, and the reasons why it was imposed. In either event, the purpose of the analysis is to form a judgment about the competitive significance of the restraint .... 435 U.S. at 692, 98 S.Ct. at 1365.

The rule of reason, therefore, is primarily a standard which gauges the economic significance of a challenged act, agreement or understanding and weighs its effect on competition and its tendency towards the enhancement of prices, limitation of output or deterioration of quality. The analysis which is subsumed in the *per se* rule is but a subset of the analytical framework which Chief Justice White first described as the "rule of reason;" that analysis applies to those agreements which because "of their pernicious ef-

fect ... and lack of redeeming virtue are conclusively presumed to be unreasonable and therefore illegal without elaborate inquiry as to the precise harm they have caused or the business excuse for their use." *Northern Pacific Ry. Co. v. United States*, 356 U.S. 1, 5, 78 S.Ct. 514, 518 (1968).

In deciding whether conduct should be characterized under the *per se* rule, the inquiry focuses on "whether the practice facially appears to be one that would always or almost always tend to restrict competition and decrease output, and in what portion of the market, or instead one designed to 'increase economic efficiency and render markets more rather than less competitive.' " *Broadcast Music, Inc. v. Columbia Broadcasting System, Inc.*, 99 S.Ct. 1551, 1562 (1979), *quoting United States v. United States Gypsum Co.*, 98 S.Ct. at 2873 n.13. Because of the unique place of price in our economic system, agreements among competitors regarding prices have always been placed in the category of those which — in the words of Chief Justice White and more recently of Justice Stevens — are because of the "nature of the contracts" *per se* illegal. *"Any combination* which tampers with the price structure is engaged in an unlawful activity. ... The act places all such schemes beyond the pale and protects that vital part of our economy against *any degree* of interference." *United States v. Socony-Vacuum Oil Co.*, 310 U.S. 150, 221, 60 S.Ct. 811, 843 (1940) (emphasis added). The prohibition against such agreements among competitors is absolute: "Price-fixing is *per se* an unreasonable restraint of trade. It is not for the courts to determine whether in particular settings price-fixing serves an honorable or worthy end." *United States v. National Association of Real Estate Boards*, 339 U.S. 485, 489, 79 S.Ct. 711, 714 (1950).

Direct action to establish uniform prices is the most obvious form of price-fixing. But it must be remembered that the ban against price-fixing reaches arrangements far more subtle than a simple agreement between competitors to charge the same price. For example, an agreement between

competitors to exchange price information is price-fixing where it merely slows the decline of prices in a falling market. *United States v. United States Gypsum Co.*, 98 S.Ct. 2864 (1978) *United States v. Container Corp. of America*, 939 U.S. 333, 89 S.Ct. 510 (1969); *see United States v. F M C Corp.*, 306 F. Supp. 1106, 1159 (E.D. Pa. 1969). An agreement between competitors to refrain from advertising their prices reduces the significance of price as a competitive factor and is also illegal *per se* as price-fixing. *United States v. Gasoline Retailers Ass'n. Inc.*, 285 F.2d 688, 691 (7th Cir. 1961); *Louisiana Petroleum Retail Dealers, Inc. v. Texas Co.*, 148 F. Supp. 334 (W.D. La. 1956); Canby and Gellhorn, *Physician Advertising: The First Amendment and the Sherman Act*, 1978 Duke L.J. 543, 578 (hereinafter "Canby and Gellhorn, *Physician Advertising*"). Even where there was no penalty for deviation from a price list on which the prices were denominated as "suggested" prices, the price list was not rigidly adhered to, and, indeed, there was not even an agreement to adhere to the price list, the agreement simply to prepare, adopt and circulate a suggested price schedule among competitors was held to be "such tampering with prices as is forbidden by the Sherman Act." *United States v. Nationwide Trailer Rental System, Inc.*, 156 F. Supp. 800, 805 (D. Kan. 1955), *aff'd per curiam*, 355 U.S. 10, 78 S.Ct. 11 (1957). *Accord, e.g., United States v. National Ass'n of Real Estate Boards, supra.* By like token, an agreement among automobile dealers to use a common price list merely as a starting point in negotiations was condemned as price-fixing. *Plymouth Dealers Ass'n v. United States*, 279 F.2d 128, 132 (9th Cir. 1960).

Only the pricing of a bulk product or service that is a unique aggregate and cannot be sold individually falls outside the *per se* category; the concerted pricing of individual goods or services has always been subject to the *per se* rule. This distinction was only recently underscored by the Su-

preme Court in *Broadcast Music, Inc. v. Columbia Broadcasting Co.*, 99 S.Ct. 1551, a case involving the issuance of blanket licenses to copyrighted musical compositions.

The BMI decision, which was unfortunately overlooked in this Court's Memorandum and Order of June 5, 1979, leaves no doubt that the *per se* rule is alive and well and is fully applicable to the horizontal price-fixing agreements at issue in this case. Through the blanket coypright license challenged in *BMI*, licensees received the right to perform any and all compositions owned by the numerous members of the defendant licensing agencies in exchange for fees which were generally based upon a percentage of the purchaser's total revenues or a flat dollar amount rather than the amount or type of music used. 99 S.Ct. at 1554-55. Noting that it had "never examined a practice like this one before", 99 S.Ct. at 1557, the Supreme Court conducted a first impression inquiry in order to determine whether the blanket coypright license should be categorized as a *per se* violation of the Sherman Act. Finding that blanket licenses had been permitted under consent decrees entered in previous antitrust litigation involving joint licensing agencies and had also been employed by Congress in the Copyright Act of 1976, the Court determined that blanket sales of copyrighted music were an essential means of protecting the rights of copyright owners while facilitating the economic use of their compositions in the entertainment industry. 99 S.Ct. at 1562-63. Because the single-fee blanket license was a unique product which no single copyright owner could offer individually, the Court found that the pricing of that single-fee blanket license did not constitute price-fixing. The licensing agent was not offering the individual goods of many sellers; it was a separate seller offering its own separate product in "a market in which individual composers are inherently unable to fully effectively

compete." 99 S.Ct. at 1564. The Court carefully and emphatically distinguished this situation from one where, as in the present case, competitors agree on prices for goods or services which they can and do sell on an individual basis.

> [T]he blanket license cannot be wholly equated with a simple horizontal arrangement among competitors. ASCAP does set the price for its blanket license, but that license is quite different from anything any individual owner could issue. The individual composers and authors have neither agreed not to sell individually in any other market nor use the blanket license to mask price-fixing in such other markets. 99 S.Ct. at 1564.

Noting that the plaintiff had not even alleged that the individual members and affiliates of ASCAP and BMI had "agreed among themselves as to the prices to be charged for the particular 'products' (compositions) offered by each of them[,]" 99 S.Ct. at 1564 n.42, the Court ruled that the blanket copyright license was not price-fixing and therefore was not subject to *per se* analysis.

Under the analytical framework which the Supreme Court employed in the *BMI* case, the doctors' fee surveys, fee agreements and fee schedules at issue in this case unarguably falls within the *per se* category.[2] Indeed, the defendants' price agreements are precisely the type of horizontal agreements on the price of individual goods and

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[2] Because such horizontal price-fixing agreements have already been determined by the Supreme Court to fall within the *per se* category, it is not necessary for this Court to repeat the first impression inquiry which the Supreme Court performed in BMI. Nor should the Court engage in Rule of Reason analysis with respect to those activities. *See, e.g.*, 99 S.Ct. at 1562 n.33 (indicating that if a burdensome analysis were to be conducted before a court could decide that a specific course of conduct fell within the *per se* category, the court might as well apply Rule of Reason analysis from the start in each case.) Because the record clearly demonstrates that the defendants' method of pricing the services sold by their individual members on a fee-for-service basis are precisely the type of arrangements which the Supreme Court has deemed subject to *per se* analysis, those inquiries are inappropriate here.

services which *BMI* describes as price-fixing within the *per se* category. *See* 99 S.Ct. at 1564. The goods and services which defendants' member doctors sell to persons insured under foundation-approved plans on a fee-for-service basis are no different than the goods and services which they sell to their other patients on a fee-for-service basis. The agreed-upon relative value schedules and conversion factors which are adopted by majority vote of the foundations' member doctors can be used and are used by those doctors to set the prices charged to all patients. Indeed, the defendants have repeatedly polled both member and non-member doctors to be sure that their "uniform fee schedules" will "approximate the charges of most physicians." (See Section II C of Memorandum in Support of Plaintiff's Motion for Summary Judgment and Permanent Injunction.)

If one were to seek in the medical marketplace an analogy to the "blanket license" which was at issue in the BMI case, it would be found in the group prepaid health plans, or "HMOs"[4] in which the patient purchases a "blanket right" to use the medical services of the plan's doctors in return for a flat capitation payment, not a payment based on utilization. *See generally* Kissam, *Health Maintenance Organizations and the Role of Antitrust Law*, 1978 Duke L.J. 487, 488-91 (hereinafter "Kissam, *HMOs.*") Because the capitation charge paid by the patient in those "package plans," has no correlation to the payment which the doctor receives for his or her services from the HMO, the setting of

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[4] The term "HMO" refers to a "health maintenance organization." While the term "HMO" is generally used to describe a group prepaid practice in which doctors' services are primarily provided by a "closed panel" of staff doctors who are reimbursed on a salaried or flat rate basis, it is sometimes also used in reference to an "open panel" plan or "independent practice association" in which doctors are reimbursed on a fee-for-service basis and do not work exclusively for the group practice. Only the former meaning is intended here. *See generally* Havighurst, *HMOs and the Market for Health Services*, 35 J. Law and Contemp. Prob. 716 (1970) (hereinafter "Havighurst, *HMOs*"); Kissam, *HMOs*.

that capitation charge could not "mask price-fixing" by doctors. *See* 99 S.Ct. at 1564. In the case of the defendant foundations, however, the very objective of the combination has been to maintain and promote the fee-for-service pricing system in which the doctor's reimbursement is based upon the individual goods and services sold to each individual patient. (See Section II of Memorandum In Support of Plaintiff's Motion for Summary Judgment and Permanent Injunction. It being undisputed that the foundations' member doctors have combined and agreed to sell their individual goods and services on an individual basis at agreed-upon prices, *per se* analysis is mandated in this case.

II.

THE AUTHORITIES CITED BY THIS COURT DO NOT JUSTIFY FINDING A TREND TOWARDS RULE OF REASON ANALYSIS IN PRICE-FIXING CASES. INDEED, THE VERY AUTHORITIES CITED AND OTHER EXPLICIT SUPREME COURT DECISIONS WHICH WERE OVERLOOKED EXPRESSLY ESTABLISH THAT THERE IS NO SUCH TREND.

In concluding that "a recent antitrust trend appears to be emerging where the Rule of Reason is the preferred method of determining whether a particular practice is in violation of the antitrust laws, Memorandum and Order of June 5, 1979, at 7, this Court cited only three authorities. *Continental T.V., Inc. v. GTE Sylvania, Inc.*, 433 U.S. 36, 97 S.Ct. 2549 (1977); *General Glass Co., Inc. v. Globe Glass and Trim Co.*, 1978-2 CCH Trade Cas. ¶ 62,231 (N.D. Ill. 1978); Handler, *Changing Trends in Antitrust Doctrine: An Unprecedented Supreme Court Term—1977*, 77 Colum. L. Rev. 979 (1977). Whatever they may say about other antitrust violations, those three authorities do not show a trend away from *per se* analysis in horizontal price-fixing cases. Indeed, the very authorities cited by this Court as

well as an abundance of other recent decisions[4] which were unfortunately overlooked in the Memorandum and Order of June 5, 1979 expressly recognize that the *per se* rule is alive and well in horizontal price-fixing cases.

Until this Court's decision, only the decision of the Federal District Court for the Northern District of Illinois in *General Glass* supported the proposition that there was a trend away from *per se* analysis in horizontal price-fixing cases. The so-called trend perceived in *General Glass*, however, was at most an unfortunate and ill-considered *obiter dictum*[5] and that solitary district court opinion can hardly be said to be a trend by itself since the court there seriously

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[4] *E.g., Broadcast Music, Inc. v. Columbia Braodcasting Co.*, 99 S.Ct. 1551, 1556 (1979); *United States v. United States Gypsum Co.*, 98 S.Ct. 2864, 2873, 2878, 2884 and nn.13, 22 (1978); *Cernuto, Inc. v. United Cabinet Corp.*, 1979-1 CCH Trade Cas. ¶ 62,509, at 76,964 (3d Cir. 1979); *United States v. Gillen*, 1979-1 CCH Trade Cas. ¶ 62,627, at 77,577-77, 579 (3d Cir. 1979); (M.D. Pa.); *United States v. Southern Motor Carriers Rate Conference, Inc.*, 467 F. Supp. 471, 486-87 (N.D. Ga. 1979); *United States v. Nu-Phonics, Inc.*, 433 F. Supp. 1006, 1011 (D. Mich. 1977), *final judgment*, 1979, 1 CCH Trade Cas. ¶ 62,252.

[5] Relying on the *General Glass* opinion as a prognosticator of trends in the antitrust law seems ill-advised for another reason. The actual holding in *General Glass* (as opposed to the dictum concerning a trend away from *per se* analysis), concerned the scope of the McCarran-Ferguson exception and *General Glass* specifically declined to follow the Fifth Circuit opinion in *Royal Drug Co. v. Group Life & Health Insurance Co.*, 556 F.2d 1375 (5th Cir. 1977), which was subsequently affirmed by the Supreme Court of the United States. 99 S.Ct. 1067 (1979). If *General Glass* is to be relied upon for its gift of prophecy, it must be done with the knowledge that it has been proven to be a false prophet.

misread the authorities it cited for finding such a trend.[6]

A 1977 law review article by Milton Handler was cited in *General Glass* and was extensively quoted by this Court in support of the idea that there is a trend away from *per se* analysis in price-fixing cases. Yet the Handler article not only does not say that there is such a trend, it expressly reaffirms the principle that the *per se* rule applies to horizontal price-fixing conspiracies. The passage from the Handler article quoted by this Court dealt solely with the Supreme Court's 1977 decision in the *Sylvania* case and the legal standard which is applicable to the vertically-imposed territorial restraints involved there. In the article's conclusion, Handler expressly acknowledges the limited impact of *Sylvania* on the traditional *per se* violations: *"Except for the traditional per se interdictions* and with the likelihood that there will be few additions in the future, it would seem

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[6] *General Glass* based this supposed trend upon only three authorities which it mentioned but briefly in a footnote without any discussion or analysis:

> This conclusion is supported by the recent decisions of the Supreme Court in *Illinois Brick v. Illinois*, 431 U.S. 720, 97 S.Ct. 2061 (1977) and in *Continental T.V. v. GTE Sylvania*, 433 U.S. 36, 97 S.Ct. 2549 (1977). In these decisions the *per se* approach of determining § 1 Sherman Act antitrust violations, *United States v. Arnold, Schwinn & Co.*, 388 U.S. 365, 87 S.Ct. 1856 (1967), was disapproved in favor of the "rule of reason" approach.
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> For a through and compelling discussion in favor of the rule of reason approach to antitrust violations, see, *Handler, Changing Trends in Antitrust Doctrine: An Unprecedented Supreme Court Term—1977*, 77 Col. L. Rev. 979 (Nov. 1977).

1978-2 CCH Trade Cases at 74,490 n.3.

Illinois Brick Co. v. Illinois was the only authority for this supposed trend away from *per se* analysis cited by *General Glass* and not by this Court. This Court was correct in not citing *Illinois Brick* because that case dealt only with the question who is entitled to recover under section 4 of the Clayton Act, 15 U.S.C. § 15, and did not consider the legality of conduct under section 1 of the Sherman Act, 15 U.S.C. § 1, did it even mention the phrases "rule of reason" and *"per se* rule." As appears from the text above, *General Glass* misconstrued the other authorities it cited as badly as it did *Illinois Brick*.

that ... the need for a factual demonstration of illegality ... is now the prevailing doctrine." 7 Colum. L. Rev. at 1038 (emphasis added). And, in another passage of his article also unfortunately overlooked by this Court, Handler puts price-fixing violations squarely within the traditional *per se* rule: "The traditional *per se* violations of section 1 are agreements fixing prices, dividing territories, curbing production, or effectuating a boycott." *Id.* at 993. It was error, then, for this Court to rely on Handler's article to support the theory that the *per se* rule is no longer applicable to horizontal price-fixing agreements[7] because his article expressly recognizes the continued applicability of the *per se* rule in such cases.

Although he is a leading member of the antitrust defense bar, Handler is still only a commentator expressing his own views and interpretations of the Supreme Court decision in *Sylvania*. The opinions in *General Glass* and by this Court that the *per se* rule has been eroded in horizontal price-fixing cases likewise trace back to their interpretations of the *Sylvania* decision. Since the *Sylvania* decision therefore becomes the fountainhead for the notion that the *per se* rule no longer applies to price-fixing cases, it is appropriate to return to *Sylvania* to see precisely what the Supreme Court actually said there.

In *Sylvania*, the Supreme Court reexamined its earlier ruling in *United States v. Arnold, Schwinn & Co.*, 388 U.S. 365, 379, 380, 87 S.Ct. 1856, 1865, 1866 (1967), where it had held that vertically-imposed territorial restraints were *per se* unlawful "after the manufacturer has parted with dominion over [an article]," but that such restraints were to be judged under the broader rule of reason when "the manufacturer retains title, dominion, and risk with respect to the product and the position and function of the dealer in ques-

[7] *Cf., Consolidated Express, Inc. v. New York Shipping Ass'n, Inc.*, 1979-1 CCH Trade Cas. ¶ 62,589, at 77,403-77, 404 (D.N.J. 1979) (rejecting defense argument for Rule of Reason analysis based on Milton Handler article and applying *per se* analysis to group boycott.)

tion is, in fact, indistinguishable from those of an agent or salesman of the manufacturer." After noting the *Schwinn* was a "sudden change" from earlier precedent, 433 U.S. at 51, 97 S.Ct. at 25, 58, and reasoning that the distinction "between sale and nonsale transactions is not sufficient to justify the application of a *per se* rule in one situation and a rule of reason in the other," *id.* at 57, the Supreme Court overruled *Schwinn's per se* prohibition of vertically-imposed territorial restraints.

Throughout its opinion, however, the *Sylvania* Court was careful to emphasize that it was concerned "only with non-price vertical restrictions." *Id.* at 51, 97 S.Ct. at 2558 n.18 (emphasis added). Indeed, Handler's view of the continued vitality of the *per se* interdiction against horizontal price-fixing is expressly supported and the contrary view in *General Glass* and in this Court's opinion is explicitly rejected in the *Sylvania* decision itself where the Supreme Court emphasized that:

> *The per se illegality of price restrictions has been established firmly for many years and involves significantly different questions of analysis and policy.* As Mr. Justice White notes, some commentators have argued that the manufacturer's motivation for imposing vertical price restrictions may be the same as for nonprice restrictions. There are, however, significant differences that could easily justify different treatment. In his concurring opinion in *White Motor Co. v. United States*, Mr. Justice Brennan noted that, unlike nonprice restrictions, "[r]esale price maintenance is not designed to, but almost invariably does in fact, reduce price competition not only *among* sellers of the affected product, but quite as much *between* that product and competing brands." Professor Posner also recognized that "industry-wide resale price maintenance might facilitate cartelizing." Furthermore, Congress recently has expressed its approval of a *per se* analysis of vertical price restrictions by repealing those provisions of the Miller-Tydings and McGuire Acts allowing fair trade pricing at the option of the

individual States. No similar expression of congressional intent exists for nonprice restrictions. *Id.* (emphasis added, citations omitted).

Apart from the dictum in *General Glass* on which this Court relied, plaintiff has not found a single case in which a trend away from *per se* analysis for horizontal price-fixing has been perceived. To the contrary, the Supreme Court as well as the lower federal courts, have consistently emphasized in opinions written after *Sylvania* that horizontal agreements to fix prices on individual goods or services are within the *per se* category. In *Professional Engineers*, decided a year after Sylvania, the Supreme Court affirmed the decisions of the district and circuit courts, which had held that a professional society's ban on solicitation by competitive bidding was unlawful *per se* under *Goldfarb v. Virginia State Bar*, 421 U.S. 773, 95 S.Ct. 2004 (1975). *United States v. National Society of Professional Engineers*, 404 F. Supp. 457 (D.D.C. 1975), *aff'd* F.2d 978 (D.C. Cir. 1977), *aff'd*, 435 U.S. 679, 98 S.Ct. 1355. Although the Supreme Court found that the ethical rule against competitive bidding was "not price-fixing as such," 435 U.S. at 692, 98 S.Ct. at 1365, it emphasized that "no elaborate industry analysis is required to demonstrate the anticompetitive character of such an agreement." *Id.*

> Price is the "central nervous system of the economy," *United States v. Socony-Vacuum Oil Co.*, 310 U.S. 150, 226 n.59, 60 S.Ct. 811, 845, 84 L.Ed. 1129, and *an agreement that "interfere[s] with the setting of price by free market forces" is illegal on its face. Id.*

Even in the brief period since *Professional Engineers* was decided, the Court has reiterated its intolerance of horizontal price-fixing on several occasions, most recently in *Broadcast Music, Inc. v. Columbia Broadcasting Co.*, 99 S.Ct. 1551 ("[The *per se*] rule is a valid and useful tool of antitrust policy and enforcement. And agreements among competitors to fix prices on their individual goods or services are among those concerted activities that the Court

has held to be within the *per se* category.") In *United States v. United States Gypsum Co.*, 98 S.Ct. 2864, 2878 n.22 (1978), the Court emphasized that the mere exchange of price information by competitors is a sufficient predicate for civil liability where there is proof of an anticompetitive effect. *See also United States v. Gillen*, 1979-1 CCH Trade Cas. ¶ 62,627, at 77,578-77,579 (3d Cir. 1979) (applying *per se* rule in criminal case).

The lower federal courts have also continued to apply the *per se* rule in horizontal price-fixing cases, as in *United States v. Nu-Phonics, Inc.*, 433 F. Supp. 1006, 1011 (D. Mich. 1977), in which the district court stated:

> Nobody would argue that price-fixing is not a *per se* violation of section 1 of the Sherman Act, and none of the defendants have [sic] taken that position. . . . No argument is more clearly an unreasonable restraint upon trade than an agreement among competitors to fix their prices, and such agreements have been *per se* violations of the Sherman Act since the early history of the Act. Id. (citations omitted.)

Another district court decision, *United States v. Southern Motor Carriers Rate Conference, Inc.*, 467 F. Supp. 471 (N.D. Ga. 1979), which involved collective rate coordination and publication by common carrier rate bureaus, reflects the current judicial trend in cases involving price restraints far more accurately than the dictim in *General Glass* which was relied upon in this Court's Memorandum and Order of June 5, 1979. That case involved the collective coordination and publication of rates by common carrier rate bureaus. Having determined that the challenged practice of collective rate coordination and publication through a rate bureau was not immune from the antitrust laws under the state action doctrine, the Noeer-Pennington doctrine or the First Amendment, the court ruled that those practices constituted *per se* violations of section 1 of the Sherman Act and entered summary judgment in favor of plaintiff.

> [T]he practice of collective rate publication easily fits the classic description of a "naked price restraint." Since *United States v. Socony-Vacuum Oil Co.*, 310 U.S. 150, 60 S.Ct. 811, 84 L.Ed. 1129 (1940), it has been established law that price-fixing among competitors is a *per se* violation of section 1 of the Sherman Act. Because the guiding principle behind all Sherman Act jurisprudence is the protection of competition, any arrangement whose purpose or effect is to inhibit price competition is illegal. Such an arrangement need not be outright cartelization, so long as it brings about the "raising, depressing, fixing, pegging, or stabilizing" of prices.
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> 467 F. Supp. at 486 (citations omitted).

Because the defendants in that case had coordinated the rates of their member carriers, the district court found that they had had the precise effect on prices which the Supreme Court has consistently condemned as *per se* illegal.

> Within the "zone of reasonableness" in which, free from regulatory interference, market forces would otherwise determine price, the defendants have displaced competition with concerted pricing decisions. In so doing, they violate the Sherman Act at its most sensitive spot. The defendants' practices of collective rate coordination and publication are *per se* violations of Section 1, subject to injunction by this court. *Id.* (Citations omitted.)

Whatever trend there may be in the legal standards applied to non-price restraints of trade, it is clear that horizontal price-fixing of individual goods or services remains *per se* unlawful.

III

HORIZONTAL PRICE AGREEMENTS AMONG COMPETITORS ARE UNIVERSALLY JUDGED UNDER THE *PER SE* RULE AND THIS COURT'S CONTRARY DECISION STANDS ALONE IN THE ANNALS OF ANTITRUST LAW

A. Horizontal Agreements To Fix Maximum Prices Are Appropriately Considered Unlawful Per Se

Although this Court's Memorandum and Order of June 5, 1979 acknowledges at one point that "[t]he *per se* rule has been applied to fixing maximum prices as well as minimum prices," Slip Op. at 6, *citing Kiefer-Stewart Co. v. Joseph E. Seagram & Sons, Inc.*, 340 U.S. 211, 71 S.Ct. 259 (1951), it nonetheless declines to follow this acknowledged authority from the Supreme Court of the United States, incongruously stating that "the two Supreme Court cases invalidating maximum price-fixing, *Kiefer-Stewart Co. v. Joseph E. Seagram & Sons, Inc., supra,* and *Albrecht v. Herald Co.*, 390 U.S. 145 (1968), need not be read as establishing a *per se* rule." Memorandum and Order of June 5, 1979, at 8. The only authority cited by this Court for not following explicit and acknowledged authority from the Supreme Court of the United States is a recent law review article which not only fails to support this Court's conclusion, but which maintains in the strongest terms that the maximum fee schedules adopted by foundations for medical care are and should be deemed unlawful *per se.* Kallstrom, *Health Care Cost Control by Third Party Payors: Fee Schedules and the Sherman Act,* 1978 Duke L.J. 645, 680-84, 691-94 (hereinafter Kallstrom, *Fee Schedules"*).

The two Supreme Court cases invalidating maximum price-fixing, *Kiefer-Stewart Co. v. Joseph E. Seagram & Sons,* 340 U.S. 211, 71 S.Ct. 259, and *Albrecht v. Herald Company,* 390 U.S. 145, 88 S.Ct. 869, clearly indicated that the *per se* standard was just as applicable to maximum

price-fixing as to minimum price-fixing, and they have accordingly and consistently been cited by the federal courts as having established a *per se* rule.* In fact, plaintiff has found no case in which any federal judge—even in dissent—said that a horizontal agreement to fix maximum prices is not *per se* unlawful. In *Kiefer-Stewart*, the Court held that an agreement between competing liquor distillers on the maximum prices at which wholesalers would sell their products violated the Sherman Act. Reversing a circuit court decision to the contrary, the Court held that:

> The Court of Appeals erred in holding that an agreement among competitors to fix maximum resale prices of their products does not violate the Sherman Act. For such agreements, no less than those to fix minimum prices, cripple the freedom of traders and thereby restrain their ability to sell in accordance with

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* Among the cases which cite *Kiefer-Stewart* or *Albrecht* for a *per se* rule are the following:

White Motor Co. v. United States, 372 U.S. 255, 260, 83 S.Ct. 696, 700 (1963); *United States v. Parke, Davis and Company*, 362 U.S. 29, 47,80 S.Ct. 503, 513 (1960); *Schwegemann Bros. v. Calvert Distillers Corp.*, 341 U.S. 384, 386, 71 S.Ct. 745, 746 (1951); *Hardwick v. Nu-Way Oil Co., Inc.*, 589 F.2d 806, 808 (5th Cir. 1979); *United States v. National Society of Professional Engineers*, 555 F.2d 978, 980-983, n.2 (D.C. Cir. 1977), *aff'd*, 98 S.Ct. 1355 (1978); *Pitchford v. Pepi, Inc.*, 531 F.2d 92, 98 n.9 (3d Cir. 1976); *Bowen v. New York News, Inc.*, 522 F.2d 1242, 1248 (2d Cir. 1975); *Greene v. General Foods Corp.*, 517 F.2d 635, 653-54 (5th Cir. 1975); *De Filippo v. Ford Motor Co.*, 515 F.2d 1313, 1317 (3d Cir. 1975); *Copper Liquor Inc. v. Adolph Coors Co.*, 506 F.2d 934, 946 (5th Cir. 1975); *E.A. McQuade Tours, Inc. v. Consolidated Air Tour Manual Committee*, 467 F.2d 178, 187 (5th Cir. 1972); *Janel Sales Corp. v. Lanvin Parfums, Inc.*, 396 F.2d 398, 402 (2d Cir. 1968); *Giradi v. Gates Rubber Company Sales Division, Inc.*, 325 F.2d 196, 199 n.5 (9th Cir. 1963); *Plymouth Dealers' Ass'n of Northern California v. United States*, 279 F.2d 128, 132 (9th Cir. 1960); *Virginia Excelsior Mills v. Federal Trade Commission*, 256 F.2d 538, 540-41 (4th Cir. 1958); *Lloyd v. United Liquors Corp.*, 203 F.2d 789, 795-96 (6th Cir. 1953); *Knutson v. Daily Review, Inc.*, 468 F. Supp. 226, 231 n.7 (1979); *Carr Electronics Corp. v. Sony Corp. of America*, 1979-1 CCH Trade Cas. ¶ 62, 540, at 77,140 (N.D. Cal.);

their own judgment. We reaffirm what we said in *United States v. Socony-Vacuum Oil Co.*, 310 U.S. 150, 223, 60 S.Ct. 811, 844, 84 L.Ed. 1129: "Under the Sherman Act a combination formed for the purpose and with the effect of raising, depressing, fixing, pegging, or stabilizing the price of a commodity in interstate or foreign commerce is illegal *per se*." 340 U.S. at 213, 71 S.Ct. at 260.

In *Albrecht*, the Court again reversed the decision of the circuit court, this time ruling that a combination between a newspaper and another company to enforce maximum retail prices for the newspaper's carriers was in violation of the Sherman Act. After restating and reaffirming the holding of *Kiefer - Stewart*, the Court ruled in no uncertain terms

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[a] *Suburban Beverages, Inc. v. Pabst Brewing Co.*, 462 F. Supp. 1301, 1306 (E.D. Wis. 1978); *DuPont Glore Forgan, Inc. v. Am. Tel. & Tel. Co.*, 437 F. Supp. 1104, 1113 (S.D.N.Y. 1977); *Crown Central Petroleum Corp. v. Brice*, 427 F. Supp. 638, 640 (E.D. Va. 1977); *Aaron E. Levine & Co., Inc. v. Calkraft Paper Co.* 29 F. Supp. 1039, 1046 (E.D. Mich. 1976); *V & L Cicione, Inc. v. C. Schmidt & Sons, Inc.*, 403 F. Supp. 643, 655 (E.D. Pa. 1975); *Call Carl, Inc. v. B P Oil Corp.*, 403 F. Supp. 568, 573-74 (D.Md. 1975); *Phillips v. Crown Central Petroleum Corp.*, 395 F. Supp. 735, 760 (D. Md. 1975); *Evans v. S.S. Kresge Co.*, 394 F. Supp. 817, 847 (W.D. Pa. 1975); *Capitol Temporaries of Hartford v. Olsten Corp.*, 383 F. Supp. 902, 909-910 (D. Conn. 1974); *Jacoby v. Bache & Co., Inc.*, 377 F. Supp. 86, 96 (S.D.N.Y. 1974); *Sunny Hill Farms Dairy Co. v. Kraftco Corp.*, 381 F. Supp. 845, 853 n.8 (E.D. Mo. 1974); *Schnappes Shop, Inc. v. H.W. Wright & Co., Ltd.*, 377 F. Supp. 570, 581-82 (E. Md. 1973); *United States v. General Electric Co.*, 385 F. Supp. 731, 734 (S.D.N.Y. 1973); *Vandervelde v. Put and Call Brokers and Dealers Ass'n*, 344 F. Supp. 118, 134, 136-37 (S.D.N.Y. 1972); *Pearl Brewing Co. v. Anheuser-Busch, Inc.*, 339 F. Supp. 945, 951-52 (S.D. Tex. 1972); *United States v. Uniroyal, Inc.*, 300 F. Supp. 84, 88-89 (S.D.N.Y. 1969); *Stanton v. Texas, Inc.*, 289 F. Supp. 884, 889 (D.R.I. 1968); *United States v. Serta Associates, Inc.*, 296 F. Supp. 1121, 1123 (N.D. Ill. 1969); *Checker Motors Corp. v. Chrysler Corp.*, 283 F. Supp. 876, 882 (S.D.N.Y. 1968); *Wurzberg Brothers, Inc. v. Head Ski Co.*, 276 F. Supp. 142, 145-46 (E.D. Tenn. 1967); *Bolick-Gillman Co. v. Continental Baking Co.*, 206 F. Supp. 151, 157 (N.D. Ohio 1961).

that maximum price-fixing is "*without more*, an illegal restraint of trade under § 1 of the Sherman Act." 390 U.S. at 153, 88 S.Ct. at 873 (emphasis added).

> *We think Kiefer-Stewart was correctly decided and we adhere to it.* Maximum and minimum price-fixing may have different consequences in many situations. *But schemes to fix maximum prices, by substituting the perhaps erroneous judgment of a seller for the forces of the competitive market, may severely intrude upon the ability of buyers to compete and survive in that market.* Competition even in a single product, is not cast in a single mold. Maximum prices may be fixed too low for the dealer to furnish services essential to the value which goods have for the consumer or to furnish services and conveniences which consumers desire and for which they are willing to pay. Maximum price-fixing may channel distribution through a few large or specifically advantaged dealers who otherwise would be subject to significant nonprice competition. *Moreover, if the actual price charged under a maximum price scheme is nearly always the fixed maximum price, which is increasingly likely as the maximum price approaches the actual cost of the dealer, the scheme tends to acquire all the attributes of an arrangement fixing minimum prices.* It is our view, therefore, that the combination formed by the respondent in this case to force petitioner to maintain a specified price for the resale of the newspapers which he had purchased from respondent constituted, without more, an illegal restraint of trade under § 1 of the Sherman Act. *Id.* (emphasis added).

The Court of appeals for the Ninth Circuit has also held an agreement among competitors on a maximum or "list" price to be a *per se* violation of the Sherman Act. *Plymouth Dealers's Ass'n of Northern California v. United States*, 279 F.2d 128 (9th Cir. 1960), involved the publication and circulation by an automobile dealers' association of a price schedule which provided a "list price" to be used as an agreed-upon starting point in bargaining with customers.

Although the "list price" had not been precisely followed in most instances, the Ninth Circuit held that the price schedule was *per se* unlawful, since it established "one boundary of 'the range within which * * * sales would be made.' " 279 F.2d at 134, *quoting Socony-Vacuum Oil Co.*, 310 U.S. at 150, 222, 60 S.Ct. at 811, 844.

Similarly, in *Vandervelde v. Put and Call Brokers and Dealers Ass'n*, 344 F. Supp. 118 (S.D.N.Y. 1972), a brokers' association rule requiring that a commodity offered for sale by any member broker be sold to another member broker at a discount from the authorized price was held to be *per se* unlawful. Reasoning that "[w]hat the rule here requires is that a maximum resale price be charged a certain class of buyers," 344 F. Supp. at 137, the district court held that the rule amounted to maximum price-fixing having significant anticompetitive effects. *See* 344 F. Supp. at 133-139.

> § 23 involves the imposition of a restriction upon the freedom of the individual members of the Association to set and abide by their own price in the limited marketplace in which they operate. Such restrictions are at the heart of the Sherman Act's prohibitions. *Id.* at 138.

Unlike *Kiefer-Stewart* and *Albrecht*, but similarly to *Plymouth Dealers Association* and *Vandervelde*, this case does not involve a vertical price restraint or resale price maintenance, but a direct horizontal agreement among sellers on the maximum prices to be paid for their services. Indeed, the facts of the present case are far more egregious than the facts of *Albrecht* or *Kiefer-Stewart*. A purely vertical restraint on prices might have a deflationary effect because the producer's incentive would be to increase volume by reducing the resale price, but the raison d'etre of horizontal price agreements is to maximize profits. As Judge Coffin concluded in a thoughtful commentary on vertical and horizontal maximum price-fixing, "an identical or parallel system of maximum prices between [competitors] is likely to become a system of minimum prices." *Quinn v. Mobil Oil Company*, 375 F.2d 273, 277-78

(1st Cir. 1967) (Coffin, J., concurring). Studies have proven what the Supreme Court and Judge Coffin surmised. When doctors know the maximum prices allowed for their services, they tend to charge at those maximum levels. *(See, e.g.,* Staff Report to the Federal Trade Commission and Proposed Trade Regulation Rule, *Medical Participation in Control of Blue Shield and Certain Other Open-Panel Medical Prepayment Plans,* at 142 (April 1978), citing Review of Administration of Dependents' Medical Care Program by the Department of the Army, Rept. to the Congress by the Comptroller General (General Accounting Office) 12-27 (May 1961) (hereinafter FTC Staff Report). It is hardly surprising, then, that when maximum price levels are not only communicated to doctors but are adopted by majority vote of a doctors' cartel, 85 to 95 percent of the cartel members charge at or above the agreed-upon rates. (See Statement of Facts Supporting Plaintiff's Motion for Summary Judgment and Permanent Injunction (hereinafter "Statement of Facts") precisely as Justice White predicted in *Albrecht*, the fee schedules adopted by the foundations' member doctors substitute the collective decision of a sellers' cartel for the forces of a competitive market, and severely intrude upon the ability of third party payors to negotiate at arm's length on the prices to be paid for doctors' services.

Thus, commentators have urged that foundations for medical care which adopt maximum fee schedules by horizontal agreement "should be recognized as part of a profit-maximizing strategy of a coalition of monopolists" and the authority of *Albrecht* and *Kiefer-Stewart* be "appropriately invoked to curb private price regulation by a cartel." Havighurst, *Professional Restraints on Innovation in Health Care Financing*, 1978 Duke L.J. 303, 377-378 (hereinafter Havighurst, *Professional Restraints.)* Indeed, the single authority on which this Court relied in disregarding the Supreme Court's judgment in *Albrecht* and *Kiefer-Stewart* strenuously advocates the application of the *per se* rule to the horizontal maximum price-fixing of foundations for

medical care. Kallstrom, *Fee Schedules, supra.* The recommendation of that author is, in fact, the very objective of the State of Arizona in prosecuting this lawsuit, that is, that "[f]ee schedules that are initiated as the independent effort of insurers ... and are negotiated with doctors who make their decisions individually, should be encouraged[,]" *id.* at 680, but fee schedules adopted by a horizontal combination of doctors and dictated to insurers in cartel fashion should be held *per se* unlawful. Id.

In the passage relied upon by this Court, Kallstrom urges that *Kiefer-Stewart* and *Albrecht* should not be read to invalidate provider agreements between individual insurers and individual doctors.[9] Unfortunately, the Court overlooked the author's analysis of the very different type of price agreement which is at issue in this case. In Section V of the Kallstrom article, which is pointedly entitled "Separating Fee Schedules from Provider Control: The Crucial Limitation," the author explains that:

> The governing rule that emerges from the prepaid drug and legal service plans is that the antitrust laws basically support such plans except to the extent that they camouflage or embody horizontal agreements by competing providers of services. Physicians may not agree as a group on an acceptable fee arrangement or suggest that arrangement to an insurer. Physicians may not combine and collectively bargain for favorable fees. A fee schedule would be illegal if it received the

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[9] Kallstrom's concerns in that regard might instead be directed to the question whether such an arrangement constitutes a "conspiracy" within the meaning of the Sherman Act. In *Group Life & Health Ins. Co. v. Royal Drug Co.*, 99 S.Ct. 1067 (1979), the Department of Justice, appearing as an amicus curiae, took the position that the Pharmacy Agreements in question there probably did not violate the antitrust laws. See 99 S.Ct. at 1072 n.5. The Arizona attorney general also maintains the position that a reimbursement schedule which is initiated as the independent effort of a third party payor and negotiated with individual doctors on an independent basis is not unlawful. This issue will presumably be determined in the *Royal Drug* litigation on remand to the district court, but it is not an issue in this lawsuit.

imprimatur of a medical association or if a medical association served as an "advisor" to an insurer in its compilation. *Id.* at 678-79.

Kallstrom then recommends as "an acceptable bright line guide" for policing fee schedules that:

> Fee schedules, to pass muster under the antitrust laws, must be unilaterally initiated by insurers and offered to individual providers for their acceptance or rejection. *Id.* at 678-79. Fee schedules that are developed with any involvement by a medical association of any kind should be condemned *per se*. Fee schedules that are initiated as the independent effort of insurers, however, and are negotiated with doctors who make their decisions individually, should be encouraged. This kind of arrangement should be approved unless there is affirmative proof that it has been abused—that it is a sham that hides an agreement among doctors, perpetrated either by a deliberate combination to fix prices or through the more subtle pressures of a medical association. Unfortunately, the fee schedule efforts that have been the most prevalent in the medical profession to date fall on the impermissible side of this antitrust analysis. *Id.* at 679-680.

In identifying foundations for medical care as "[p]erhaps the most blatant examples of concerted provider involvement in fee setting arrangements," *id.* at 680, Kallstrom warned against their anticompetitive impact.

> One should note the crucial distinction between the efforts of FMCs (foundations for medical care), which are run by organized medicine, and the cost-containment measures suggested in this Article. Because of the medical society sponsorship of FMCs, their maximum price control takes on a horizontal aspect not present in insurer-initiated plans. The price-determining activities of the foundations go far beyond the limits indicated by the data dissemination cases. Structurally, FMCs closely resemble the proposed bar-sponsored prepaid legal insurance plans to which the Justice Department has objected on Sherman Act

> grounds. It should come as no surprise then that FMC-type provider price-control activities, especially some of the Blue plans, are being attacked as anticompetitive. Professor Havighurst has forcefully argued that the very purpose of FMCs is to set an entry-discouraging price that will preclude other forms of third party competition and thus that a *per se* rule would be appropriate to condemn them.[10]

Clearly, this Court's decision *not* to apply a *per se* rule to this "blatant example of concerted provider involvement in fee setting arrangements" cannot be supported by the single commentator on whom the Court relied.

B. Because Uniform Pricing Is Their Purpose and Result, The Fee Schedules Adopted By The Foundations' Member Doctors Are Clearly Within The Per Se Category.

The By-Laws of the defendant foundations expressly provide for the adoption of "uniform fee schedules" by majority vote of their member doctors, and the record clearly establishes that those fee schedules—only lately referred to as "maximum" rather than "uniform" fee schedules—have had the purpose and effect of encouraging price uniformity among doctors. As is more fully described in the Memorandum in Support of Plaintiff's Motion for Summary Judgment and Permanent Injunction, it is undisputed that the defendants have repeatedly conducted preliminary surveys and meetings of their member doctors and various specialty societies of doctors in order to be sure that the fee schedules proposed to their membership represented the majority of doctors' charges. Also undisputed is the fact

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[10] *See* Havighurst, [*Health Maintenance Organizations and the Market for Health Services*, 35 Law & Contemp. Prob. 716,] 769-77 [(1970) *cf.* Egdahl, [*Foundations for Medical Care*, 283 New England J. Med. 491,] at 496 [(1973)] (VJC operations could destroy the viability of third party issuers and independent intermediaries in the health care delivery system). *But see* Comment, [*Private Physician Unions: Federal Antitrust and Labor Law Implications*, 20 U.C.L.A.L Rev. 983,] at 1009-10 [(1973)].

that both current and future prices were discussed and agreed upon in the polls and meetings which were instigated by the defendants. Defendants admit that the results of their preliminary price surveys and price agreements were used in preparing the fee schedules which were proposed to their membership for adoption, and that the membership was often advised before they voted on the proposed fee schedules that the proposals represented a "consensus" on the fees charged by a majority of doctors in the community or that they had already been adopted by the members of a sister foundation. The record clearly establishes, moreover, that the fee schedules which defendants proposed to their members were set above the average or median level of doctors' fees at the time the membership ballot was taken and that after the proposed fee increases were approved by the defendants' member doctors, 85 to 95 percent of those doctors billed at or above the agreed-upon rates. It is, then, a matter of record that defendants' price agreements have produced substantial uniformity in the prices charged by the defendants' member doctors, who have represented a significant portion of the fee-for-service doctors in their communities.

Because the defendants' price agreements unquestionably had the purpose and effect of encouraging uniform pricing by doctors, they are clearly within the *per se* category. Since the earliest interpretations of the Sherman Act by the Supreme Court, agreements to fix uniform prices have consistently been held *per se* unlawful. *E.g., United States v. Trenton Potteries Co.*, 273 U.S. 392, 47 S.Ct. 377, (1927).

> Beginning with *United States v. Trans-Missouri Freight Association, supra*, and *United States v. Joint Traffic Association*, 171 U.S. 505, 19 S.Ct. 25, 43 L.Ed. 259, where agreements for establishing reasonable and uniform freight rates by competing lines of railroads were held unlawful, it has since often been decided and always assumed that uniform price-fixing by those controlling in any substantial manner a trade or busi-

> ness in interstate commerce is prohibited by the Sherman Law, despite the reasonableness of the particular prices agreed upon. *Id.* at 398, 47 S.Ct. at 380

On the few occasions when lower federal courts have spared horizontal price-fixing agreements from the application of the *per se* rule, they have been reversed by the Supreme Court. *E.g., Goldfarb v. Virginia State Bar*, 497 F.2d 1 (4th Cir. 1974), *rev'd*, 421 U.S. 773, 95 S.Ct. 2004 (1975). In *United States v. McKesson and Robbins, Inc.*, 351 U.S. 305, 76 S.Ct. 937 (1956), for example, the district court ruled that "fair trade price-fixing by a producer-wholesaler was not *per se* illegal under the Sherman Act," even though the price-fixing agreements with independent wholesalers at the issue in that case were horizontal in character. 351 U.S. at 309, 76 S.Ct. at 940. Noting that the Miller-Tydings Act did not apply to horizontal price agreements, the Supreme Court ruled that "[t]he District Court was plainly in error in attempting to create a category of agreements which are outside the exemption of those Acts but which should nevertheless be spared from application of the *per se* rule. 351 U.S. at 311, 76 S.Ct. at 941. As the Court stated in *United States v. National Ass'n of Real Estate Bds.*, 339 U.S. 485, 489, 79 S.Ct. 711, 714 (1950):

> Price-fixing is *per se* an unreasonable restraint of trade. *It is not for the courts to determine whether in particular settings price-fixing serves an honorable or worthy end. An agreement, shown either by adherence to a price schedule or by proof of consensual action fixing the uniform or minimum price, is itself illegal under the Sherman Act, no matter what end it was designed to serve.* That is the teaching of an unbroken line of decisions.

Given that unbroken line of decisions and the broad language and purpose of the antitrust laws, the federal courts have strongly disfavored exceptions to the established stan-

dards for antitrust liability. *See, e.g., Reiter v. Sonotone Corp.*, 47 U.S.L.W. 4672 (Sup. Ct., June 11, 1979); *Group Life and Health Ins. Co. v. Royal Drug Co.*, 99 S.Ct. 1067 (1979). As the district court commented in *Goldfarb:*

> The scope of the statutory language in the Sherman Act is so expansive that courts have been reluctant to find exceptions. The language explicitly states that "every contract, combination or conspiracy which restrains commerce among several states is unlawful." Illustrative of this reluctance is the refusal to extend baseball's exempt status to other professional sports. *See Radovich v. National Football League*, 352 U.S. 445 (1957); *United States v. International Boxing Club*, 348 U.S. 236 (1955). The fact that specific exemptions are clearly delineated suggests that ambiguities should be resolved in favor of inclusion. This is especially true where price-fixing is involved since it has been declared both pernicious and lacking in any redeeming social value. 355 F. Supp. 491, 493 (citations omitted).

Recognizing and applying the established *per se* rule for horizontal price-fixing, the Court of Appeals for the Ninth Circuit has held it *per se* unlawful for a "uniform list price," *Plymouth Dealers Ass'n of Northern California v. United States*, 279 F.2d at 133, or a published but voluntary fee schedule, *Northern California Pharmaceutical Ass'n v. United States*, 306 F.2d at 379, 385-392 (9th Cir. 1962), *cert. denied*, 371 U.S. 862, 83 S.Ct. 119 (1962), to be produced by an association of competitors.

In this case, as in *United States v. Utah Pharmaceutical Ass'n*, 201 F. Supp. 29 (D. Utah 1962), *aff'd*, 371 U.S. 24, 83 S.Ct. 119 (1962), clear evidence

> of an established purpose, policy and project of the defendant Association[s], and stipulated [admitted] facts and exhibits that are clearly admissible as acts and declarations in furtherance of the objectives of the Association[s], leave no room for doubt that the officers and directors, with the intent of establishing

> uniform prices ... to the extent of their ability, adopted a pricing schedule and successive revisions, distributed them to members [and non-members] throughout the State and urged and induced the members to use the schedule for the pricing of prescription drugs. 201 F. Supp. at 34. *Accord, Northern California Pharmaceutical Ass'n v. United States*, 306 F.2d 379.

Under these circumstances, this case is clearly governed by *Goldfarb v. Virginia State Bar*, 421 U.S. 773, 95 S.Ct. 2004 (1975). In *Goldfarb*, the district court followed the authority of the Supreme Court and the Court of Appeals for the Ninth Circuit in holding that a minimum fee schedule for legal services was a *per se* violation of section 1 of the Sherman Act.

> This type of price-fixing has been held under other circumstances to be repugnant to the philosophy of the Sherman Act. *Plymouth Dealers Ass'n v. United States*, 279 F.2d 128 (9th Cir. 1960). It is contrary to the spirit of competition which sustains a free enterprise system in that it prevents competitors from using their own judgment in determing the value of their own services. *Keifer-Stewart Co. v. Seagram and Sons*, 340 U.S. 211, 213 (1951) ... [A] defendant's liability under the Sherman Act depends not on actual adherence to the schedule but rather on the mere existence of an agreement which restricts competition by price-fixing. United States v. Socony-Vacuum Oil Co., 310 U.S. 150 (1940); *Plymouth Dealers' Ass'n v. United States, supra.* 355 F. Supp. at 493-94.

The Court of Appeals for the Fourth Circuit reversed the district court's holding of liability, 497 F.2d 1 (4th Cir. 1973), but was in turn reversed by the Supreme Court. 421 U.S. 773 at 793, 95 S.Ct. and 2016. Emphasizing that "the price information disseminated [had] not concern[ed] past standards, but rather minimum fees to be charged in future transactions, and [that] those minimum rates [had been] increased over time[,]" 421 U.S. at 781, 95 S.Ct. at 2010, the

Supreme Court held that "here a naked agreement was clearly shown, and the effect on prices is plain." 421 U.S. at 782, 95 S.Ct. at 2010.

Commentators have recommended that the compilation and updating of relative value schedules by doctors' associations should be deemed *per se* unlawful even in the absence of agreements on the conversion factors to be used with those relative value schedules, because the maintenance and use of agreed-upon realtive value schedules is sufficient by itself to produce price uniformity. As explained by Kallstrom,

> The problems arise because price information activities of trade associations tend, whatever their ostensible purpose, to promote price uniformity. Due to the central and commanding market position occupied by a medical society, competing value scales are discouraged and providers are exhorted by the social pressures of the profession to design charges in accordance with the society's value schedule. The compilation and presentation of these schedules at medical society meetings facilitates the stabilization of prices because a provider can pigeonhole his charge schedule by mentioning a couple of past charges or by referring to his conversion factor and because an upward adjustment in the value of any service would result in an across-the-board increase in its price. . . .
>
> The compilation of relative value data by medical societies offends the Sherman Act because it requires the exchange of specific price information among competitors and tends to stabilize the prices of medical care in the affected community. Little would be lost and much might be gained by forbidding this activity as *per se* illegal under the Sherman Act. Providers will have to make charges with less sure knowledge of the price structures utilized by other providers, but this fact of life will improve competition, not defeat it. The sincerity and accuracy of some professionally designed relative value studies would be sacrificed, but equally reliable schedules can be drafted by competing insur-

ers engaged in arm's length bargaining with providers of care. Since no exigency appears which can justify professional participation in preparing and promoting relative value schedules, a rule condemning it seems appropriate. Kallstrom, *Fee Schedules*, supra at 693-94.

In this case there is a clear record of concerted agreements not just on the relative value schedules to be used by doctors, but on the dollar conversion factors as well. Moreover, it is not necessary for this Court to presume that price uniformity results from the defendants' challenged price agreements; the defendants have admitted that overwhelming price uniformity has occurred.[11] On this record the *per se* rule is clearly applicable.

IV.

THE *PER SE* RULE IS FULLY APPLICABLE TO COMMERCIAL HORIZONTAL AGREEMENTS AMONG PROFESSIONALS FIXING OR STABILIZING PRICES

In its Memorandum and Order of June 5, 1979, at 8-12, this Court concluded that the challenged conduct in the instant case should not be analyzed under the *per se* rule because that conduct involved a "profession" rather than a "commercial business." Plaintiff respectfully submits that under the prevailing case law the correct predicate for application of the *per se* rule in this case is not whether the defendant is a "profession," or a "commercial business" but

[11] In *Goldfarb*, the Supreme Court deplored the fact that the minimum fee schedule had created a market characterized by such price uniformity that "consumers could not turn to alternative sources for the necessary service." 421 U.S. at 782, 95 S.Ct. at 2010. Here the evidence shows that 85 to 95 percent of defendants' members use the foundation fee schedule as a price floor. Whatever the hardship borne by the consumers *who* sought legal services in connection with a real estate transaction in *Goldfarb*, it could not be greater than that of the Arizona citizen who needs medical assistance and must seek in that time of need the one doctor in 20 who might charge less than the agreed-upon fee adopted by the foundations' members.

whether the conduct at issue is the commercial business of a profession. The distinction between the commercial conduct of professionals, which is appropriately subject to the *per se* standard, and the non-commercial aspects of the professions which are more appropriately analyzed under the Rule of Reason, has been applied by the federal courts and recommended by the commentators, including those cited by this Court.

A comprehensive study of the application of the antitrust laws to the so-called "learned professions" is found in *United States v. Oregon State Bar*, 385 F. Supp. 507, 513-17 (D. Ore. 1974). Determining that the Supreme Court had left open "the question whether there is a 'learned profession' exemption to the Sherman Act," the district court in that case reviewed and analyzed the existing body of case law on that question and concluded that there was no "learned profession exemption." 385 F. Supp. at 515-16. It being the province of Congress rather than the courts to create exemptions from the Sherman Act, the court stated, "[i]t is not for this court to create a new exemption to the Sherman Act for so-called 'learned professions.'" 385 F. Supp. at 516. The court emphasized that an exemption based on professional status was particularly inappropriate where the conduct at issue was price-fixing.

> [T]he argument for exempting price-fixing activities of a "learned profession" is significantly weaker than the argument for exemption of other professional activities. Price-fixing is a *per se* violation of the Sherman Act. 385 F. Supp. at 516 (citation omitted).

Noting that several cases had indicated "that a viable line might be drawn between the 'commercial and noncommercial' activities of a profession," *id.* (citations omitted) the court concluded that the fee schedules for legal services which were at issue in that case could not be granted an exemption from antitrust liability.

> [t]here is no more commercial element to the practice of law than the setting of fees. Thus, even the acceptance by this Court of the exemption of noncommercial professional activities from the Sherman Act would not save defendant's fee schedules. 385 F. Supp. at 517.

Indeed, the Court of Appeals for the Ninth Circuit had previously ruled in another case involving horizontal price-fixing that the professional status of pharmacists could not provide them an exemption from antitrust liability. *Northern California Pharmaceutical Ass'n v. United States*, 306 F. Supp. 379, (9th Cir. 1962). Denominating professional status as "utterly irrelevant in the *instant* case," *id.* at 384 (emphasis in original), the Ninth Circuit held that no antitrust exemption was available "in an area of 'entrepreneurial,' rather than professional activity." [A] *prima facie* case of an agreement to fix prices" having been presented, the Ninth Circuit held the pharmaceutical associations price-fixing conduct to be unlawful under the *per se* rule. 306 F.2d at 385. *Accord, United States v. Utah Pharmaceutical Ass'n*, 201 F. Supp. at 33-34.

As the district court of *Goldfarb* aptly noted, "fee setting is the least 'learned' part of [a] profession." 355 F. Supp. at 495.

> The Court has some question whether the adoption of a minimum fee schedule is itself "professional." It seems to the Court that there is a basic inconsistency between the lofty position that professional services, not commodities, are here involved and the position that a minimum fee schedule is proper. The former properly contemplates differences in abilities worth and energies expended of those rendering the services. Such differences are made as meaningless by a minimum fee schedule as they would be by a maximum fee schedule. Although there is as yet no evidence of this

> here, the minimum fee schedule does permit the charging, by an attorney, of more than the services are worth. Certainly fee setting is the least "learned" part of the profession. *Id.*

This rationale was vindicated by the Supreme Court, which, finding no Sherman Act exemption for a "profession," held the fee schedules in question to be unlawful. 421 U.S. at 788, 95 S.Ct. 2014.

In its Memorandum and Order of June 5, 1979, *Goldfarb* did note the possibility that

> [t]he public service aspect, and other features of the professions, may require that a particular practice, which could properly be viewed as a violation of the Sherman Act in another context, be treated differently. *Id.* at 788, 95 S.Ct. at 2013 n.17.

But whatever "public service aspect" of a profession might merit special judicial treatment, that special treatment is not appropriate in a case of horizontal price-fixing, for *that* was precisely the conduct which *Goldfarb* held unlawful.

The Supreme Court's opinion in *Professional Engineers* certainly does not support this Court's ruling that horizontal price-fixing may be exempted from the *per se* rule when the defendant in the case is somehow engaged in a profession."

In *Professional Engineers,* the defendant professional group attempted to read into *Goldfarb's* footnote 17 an exemption from *per se* analysis which would extend to its ethical rule against solicitation by competitive bidding. As the district court described it,

> Defendant claims to detect in the *Goldfarb* case, particularly Footnote 17, a directive that a profession's activities and code of ethics are to be judged not under the traditional *per se* doctrine but under the rule of reason. 404 F. Supp. at 460.

That reading of *Goldfarb* was rejected by the district court, which held the ban on competitive bidding to be a *per se* violation of section 1 of the Sherman Act. 404 F. Supp. at 461.

> The Court rejects defendant's contention for a number of reasons. First, such a construction would substantially undermine the *Goldfarb* Court's denial of a total or partial exemption from antitrust regulation for professions. Neither the nature of an occupation nor any alleged public service aspect provides sanctuary from the Sherman Act. *Goldfarb, supra,* 421 U.S. at 787, 95 S.Ct. 2004. Second, *Goldfarb* does not rest upon a rule of reason analysis. The Court found price-fixing activities and condemned them outright. Third, Footnote 17 apparently distinguishes between a profession's business aspect, and its valid self-regulatory "restraints," such as membership requirements or standards of conduct. Price-fixing, however, receives no privileged treatment when incorporated into a code of ethics. Fourth, the activities at issue here have a wide-ranging commercial impact and therefore are to be judged by normal antitrust standards applicable to business practices. Fifth, while NSPE claims that its ban on competitive bidding protects public safety and health, the Supreme Court in *Goldfarb* had before it and rejected similar arguments aimed at preventing "cheap but faulty work" by professionals. The age-old cry of ruinous competition, competitive evils, and even public benefit cannot justify price-fixing. As Justice Douglas stated in *United States v. Socony-Vacuum Oil Co., supra,* "Any combination which tampers with price structures is engaged in an unlawful activity." 310 U.S. at 221, 60 S.Ct. at 843. *Id.* (footnotes omitted.)

In an opinion written by Judge Leventhal, the Court of Appeals for the District of Columbia Circuit affirmed and adopted the district court's analysis.

> The district court correctly appraised the rule before it as one that at its core "tampers with the price structure," and is therefore illegal without regard to claimed or possible benefits. 555 F.2d at 984.

The Supreme Court granted certiorari "to decide whether the District Court should have considered the factual basis for the [society's] proffered justification [that the ethical rule in question had been adopted by members of a learned profession for the purpose of minimizing the risk that competition would produce inferior engineering work endangering the public safety]." 455 U.S. at 681, 98 S.Ct. at 1360. Stating that "the cautionary footnote in *Goldfarb*, 421 U.S. at 788-789, n.17, 95 S.Ct. at 2013, . . . cannot be read as fashioning a broad exemption under the Rule of Reason for learned professions." the Supreme Court specifically distinguished "[e]thical norms [which] may serve to regulate and promote . . . competition, and thus fall within the Rule of Reason" from the complete ban on competitive bidding which was at issue in that case, 435 U.S. at 696, 98 S.Ct. at 1367, and affirmed the decision of the District of Columbia Circuit. Id. at 699, 98 S.Ct. at 1369.[12]

Thus, the required predicate for applying the Rule of Reason to professional restraints of trade is *not* "that a profession is involved," Memorandum and Order of June 5, 1979, at 9, but that the conduct at issue is an "ethical norm which may serve to regulate and promote . . . competition." Conversely, *per se* analysis is appropriate when the conduct

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[12] Even more recently, the Supreme Court indicated that doctors' control of the reimbursement schedules of thire party payros should not be granted any exemption from established anatitrust standards.

> [E]xempting provider agreements from the antitrust laws would be likely in at least some cases to have serious anticompetitive consequences. Recent studies have concluded that physicians and other health are providers typically dominate [certain insurance plans.] Thus, there is little incentive on the part of [the insurer] to minimize costs, since it is in he interest of the providers to set fee schedules at the highest possible level. *Group Life & Health Insurance Co. v. Royal Drug Co.*, 99 S.Ct. 1067, 1083-84 n.40 (1979).

at issue involves the "commercial business" of a profession and has been determined by the Supreme Court to fall within the *per se* category.

The application of the *per se* rule where "a profession is involved" was succinctly described in *Veizaga v. National Bd. for Respiratory Therapy*, 1977-1 CCH Trade Cas. ¶ 61,274, at 70,870 (N.D. Ill. 1977):

> Where professional organizations are alleged to have commited a *per se* offense, a two-step analysis is required. First, the court must determine whether the challenged activity is, by its nature and character, commercial. If the court should find that it is commercial, the professional organization may be liable for a *per se* offense. However, if the court should find the activity to be noncommercial, it should then apply a rule of reason analysis, using the factors outlined in *Board of Trade v. United States*, 246 U.S. 231 (1917). We believe that the second step is necessary to ensure that those professional activities, while noncommercial in their character, but unreasonable (in the antitrust sense) in their impact, are subject to the antitrust laws. This analysis satisfies the concern of the Court that professions should be subject to the antitrust laws but still be treated differently where the public service aspects of the professions are involved. *Id.*

Plaintiff respectfully submits that this standard, rather than one based on professional status alone, is required by the prevailing case law.

The Ninth Circuit's decision in *Boddicker v. Arizona State Dental Ass'n*, 549 F.2d 626 (9th Cir. 1977), is fully compatible with that standard. Although *Boddicker* preceded the Supreme Court's decision in *Professional Engineers*, the Ninth Circuit rejected the defendants' contention in that case that their challenged practice of conditioning membership in a local dental association on membership in a national dental association was exempt from antitrust scrutiny because it involved a "learned profession." Significantly, the practice in question was *not* a

direct restraint on price or any other commercial aspect of dentistry, but merely a rule setting the conditions for membership in local dental associations. Focusing on the nature of the conduct at issue, the court restated in different terms the rule set forth in *Veizaga*.

> As we interpret [the Supreme Court's opinon in *Goldbarb*], to survive a Sherman Act challenge a particular practice, rule, or regulation of a profession, whether rooted in tradition or the pronouncements of its organizations, must serve the purpose for which the profession exists, *viz.* to serve the public. Those which only suppress competition between practitioners will fail to survive the challenge. This interpretation permits a harmonization of the ends that both the professions and the Sherman Act serve. 549 F.2d at 632.

Where the conduct at issue is horizontal price-fixing, the professional status of the defendants can afford them no exception from *per se* analysis. *See, e.g., Ballard v. Blue Shield*, 543 F.2d 1075, 1079 (4th Cir. 1976) (holding professional status of defendants immaterial under *Goldfarb* since case involved alleged restraint and monopolization of a commercial aspect of the practice of medicine, "as distinguished from such other aspects as the professional qualifications of the practitioner"); *Feminist Women's Health Center v. Mohammed*, 586 F.2d 530, 546-47 (5th Cir. 1978) (holding *per se* analysis applicable to concerted activity of doctors, even in enforcing professional standards, where anticompetitive purpose was shown).

In this case, there is no question that "the challenged activity is by its nature and character, commercial." Indeed, the defendant foundations were founded to serve the purely commercial purpose of promoting the practice of medicine on a fee-for-service basis. Moreover, it is difficult to imagine conduct more commercial in nature that the price-fixing activities of these commercial trade associations. Considering the monopoly power of their membership and the anticompetitive impact of their conduct against the stan-

dard established by the Supreme Court for identifying unreasonably restrictive practices, it is clear that the challenged activity here falls within the category of *per se* violations. *See* Havighurst, *Professional Restraints, supra* at 377-378. Havighurst, *HMOs, supra* at 768; Kallstrom *Fee Schedules, supra* at 660, 692 n.197.

The commentators, including those cited by this Court, agree that horizontal price-fixing by professions is and should be subject to *per se* analysis. In its Memorandum and Order of June 5, 1979, at 9, this Court quoted from a student law review comment. Comment, *The Professions and Noncommercial Purposes: Applicability of Per Se Rules under the Sherman Act*, 11 U. Mich. J. of Law Reform 387 (1978) (hereinafter "Comment, *The Professions and Noncommercial Purposes.*" As the title of that comment indicates, its author was primarily concerned with the noncommercial aspects of professions, as described in the passage of the comment from which the Court quoted. He argues—as the prevailing case law holds—that the Rule of Reason should be applied to professional conduct which is (a) within the legitimate self-regulatory powers of the profession, (2) not primarily profit-oriented or commercial in purpose, and (3) undertaken in good faith. *Id.* at 399-400. But he also argues that conduct which does not meet those three requirements should *not* be excepted from *per se* treatment, particularly since *Goldfarb* and its progeny . . . indicate that some activities by professions, such as price-fixing, simply are devoid of any noncommercial purpose."

Id. at 399.[13] Thus, the Comment on which the Court relied actually concludes that "[p]*rice-fixing, . . . and other egregious activities should not escape per se condemnation* simply because they enjoy the respectability of having been mandated by the ethical rules of a given profession." *Id.* at 413 (emphasis added).

This conclusion accords with those of more mature commentators,[14] including Professor William Canby and Dean Ernest Gellhorn who, having studiously examined the application of the antitrust laws to physicians, conclude that "*price-fixing or equivalent conduct* (including fee advertising bans), allocation of clients, some forms of group boycotts and perhaps tying arrangements *will be subject to per se rules.*" Canby and Gellhorn, *Physician Advertising, supra* at 578. Indeed, Canby and Gellhorn predict that when a medical society's regulation of physician practices fits within one of those "egregious categories," it will not be necessary to show the actual competitive impact of the practice, "nor will an antitrust court hear, much less accept, organized medicine's justifications for the restraint." *Id.* Similary, Professor Clark Havighurst, a respected authority on the subject of the application of

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[13] See *id.* at n.36:

Indeed, there is nothing to indicate that the Supreme Court in *Goldfarb* was not applying a per se rule to the price-fixing arrangement in that case, and at least one federal court has so concluded. *See United States v. National Soc'y of Prof. Eng's*, 404 F. Supp. 457 (D.D.C. 1975), *aff'd*, 46 U.S.L.W. 4356 (1978). In oral argument before the Court in *Goldfarb*, Solicitor General Bork in fact pointed up the commercial-noncommercial dichotomy: "One searches in vain for any connection between professional ethics and price-fixing, and one searches in vain for the principle that price-fixing is ethical." 43 U.S.L.W. 3521, 3522 (1975).

[14] The second student note cited by this Court deals only with the self-regulation of professions and does not comment on the applicability or inapplicability of *per se* analysis to price-fixing by a professional group. Note, *Application of the Antitrust Laws to Anticompetitive Activities by Physicians*, 30 Rutgers L. Rev. 991 (1971).

the antitrust laws to the health care industry, persuasively argues that physicians' fee schedules, and particularly the fee schedules adopted by foundations for medical care, should be treated as *per se* unlawful. Havighurst, *HMO's and the Market for Health Service*, 35 J. Law and Comtemp. Prob. 716, 773 (1970). Accord, Kallstrom, *Fee Schedules, supra* at 680-84, 691-94.

Because the horizontal price-fixing challenged in this case is wholly commercial in nature and character, the *per se* rule is fully applicable here. Because this Court's ruling that an exemption from the *per se* rule exists in a case of horizontal price-fixing when "a profession is involved" is in conflict with the overwhelming weight of authority on this question, this motion for reconsideration should be granted.

V.

IF THIS COURT CONTINUES TO REFUSE TO APPLY THE *PER SE* RULE, THE DECISION SHOULD BE CERTIFIED FOR INTERLOCUTORY APPEAL UNDER 28 U.S.C. § 1292(b) BECAUSE THE DECISION IS A CONTROLLING QUESTION OF LAW AS TO WHICH THERE IS A SUBSTANTIAL GROUND FOR DIFFERNCE OF OPINION AND A DIRECT APPEAL WILL MATERIALLY ADVANCE THE ULTIMATE TERMINATION OF THE LITIGATION.

There can be little question that this Court's refusal to apply the *per se* rule to a horizontal price-fixing conspiracy presents a controlling question of law as to which there is a substantial ground for difference of opinion. In the unlikely event that this Court does not grant this motion for reconsideration or plaintiff's motion for summary judgment and permanent injuction, the certification of this case for interlocutory appeal would materially advance the ultimate termination of the litigation and preserve the resources of this Court and all of the parties by avoiding an unnecessary trial. *See, e.g., Reiter v. Sonotone Corp*, 47 U.S.L.W. 4672 (Sup. Ct., June 11, 1979); *In re Sugar Antitrust Litigation*,

588 F.2d 1270 (9th Cir. 1978); *Memorex Corp. v. International Business Machines Corp.*, 555 F.2d 1379 (9th Cir. 1977); *Little v. First California Co.*, 532 F.2d 1302 (9th Cir. 1976); *Duchess Music Corp. v. Stern*, 458 F.2d 1305 (9th Cir. 1972).

VI.

CONCLUSION

WHEREFORE, in the event that this Court does not grant plaintiff's concurrent motion for summary judgment and permanent injunction, Plaintiff the STATE OF ARIZONA respectfully prays that this Court enter its order:

1. Vacating the Memorandum and Order dated June 5, 1979, insofar as it denied plaintiff's motion for partial summary judgment on the issue of liability, and

2. Granting plaintiff's motion for partial summary judgment on the issue of liability, or, alternatively,

3. Certifying that insofar as it denied plaintiff's motion for partial summary judgment on the issue of liability the Memorandum and Order dated June 5, 1979, involves a controlling question of law as to which there is a substantial ground for difference of opinion and that an immediate appeal from that portion of the order may materially advance the ultimate termination of the litigation.

DATED this 6th day of July, 1979.

(Signature omitted in printing.)

Verified JUL 13, 1979

(Caption omitted in printing.)

SUPPLEMENTAL RESPONSE OF THE STATE OF ARIZONA TO DEFENDANT MARICOPA FOUNDATION FOR MEDICAL CARE'S FIRST SET OF INTERROGATORIES

Plaintiff STATE OF ARIZONA hereby supplements its Response to Interrogatories 3, 22-26, 29 and 32 of defendant Maricopa Foundation for Medical Care's First Set of Interrogatories, incorporating herein all objections set forth in plaintiff's initial response to those interrogatories and without in any way waiving or intending to waive but rather preserving and intending to preserve:

1. All questions as to the competency, relevancy, materiality, privilege and admissibility of these answers or the subject matter thereof, as evidence for any purpose, and all objections to the use of any of them for any purpose in any subsequent stage of this action or in any other proceeding,
2. The right to object on any ground at any time to demand for further response to these or any other interrogatories or other discovery procedures involving or relating to the subject matter of the interrogatories herein answered; and
3. The right at any time to revise, correct, add to or clarify any of the answers herein.

INTERROGATORY NO. 3(b)

With respect to paragraph 7, set forth by year the sums you pay . . . (b) "directly to doctors for services, goods and equipment."

SUPPLEMENTAL RESPONSE:

Without waiving or intending to waive any objection with respect thereto, the information sought may be derived or ascertained in part from the records of the Arizona Depart-

ment of Economic Security, the Arizona Department of Health Services, the Arizona State Hospital, and the Industrial Commission of Arizona produced by plaintiff for inspection and copying by defendants in response to defendant Maricopa Foundation for Medical Care's First Request for Documents and Tangible Things, as well as the documents of certain other state agencies or programs which have previously been made available for inspection in response to that Request for Documents and Other Tangible Things.

INTERROGATORY NO. 22

Identify each (a) relative value schedule; (b) unit conversion factor; and (c) fee schedule established, maintained, revised or stabilized by you and with respect to each identify all documents, agreements, proposals, promises, forecasts, commitments, understandings, actions, representations and communications relating to it.

SUPPLEMENTAL RESPONSE:

Without waiving or intending to waive any objection with respect thereto, plaintiff answers as follows:

Pursuant to Ariz. Rev. Stat. Ann. § 8-512, the Arizona Department of Economic Security has established and adopted a schedule setting out maximum allowable fees which the Department deems reasonable for services provided by the Department pursuant to that section. That fee schedule has been published as DES Rule R6-5-6001 and produced with related documents of the Department by plaintiff.

Pursuant to Ariz. Rev. Stat. Ann. § 23-908(B) the Industrial Commission of Arizona has adopted a schedule of fees for doctors' services to injured employees covered by the Workmen's Compensation Program of the State of Arizona. Copies of that fee schedule and documents relating to

it will be produced by plaintiff for inspection and copying by defendants pursuant to plaintiff's Supplemental Response to Defendant Maricopa Foundation for Medical Care's First Request for Documents and Tangible Things.

With respect to the various other health programs administered by the Department of Economic Security, the Department of Health Services (including the Crippled Children's Hospital and the Arizona State Hospital) and the Department of Corrections, the information sought may be derived or ascertained from the records of those agencies produced by plaintiff for inspection and copying by defendants pursuant to plaintiff's Supplemental Response to Defendant Maricopa Foundation for Medical Care's First Request for Production and Tangible Things, and the additional documents which plaintiff has primarily made available for inspection by defendants.

INTERROGATORY NO. 23

Identify each office, agency, commission, department, division or other organizational entity of the State of Arizona which has participated at any time in any way in the preparation, establishment, maintenance, revision or stabilization of any (a) relative value schedule, (b) unit conversion factor or (c) fee schedule.

RESPONSE

Without waiving or intending to waive any objection with respect thereto, plaintiff answers as follows:

The Department of Economic Security has established and adopted a schedule setting out maximum allowble fees which the Department deems reasonable for services provided by the Department pursuant to Ariz. Rev. Stat. Ann. § 8-512, as described in plaintiff's response to Interrogatory No. 22.

The Industrial Commission of Arizona has established and adopted a schedule of fees for doctors' services to injured employees covered under the Workmen's Compensation Program of the State of Arizona pursuant to Ariz. Rev. Stat. Ann. § 23-908(B).

In addition, other agencies, departments and programs of the State of Arizona may have used or referred to various relative value schedules, unit conversion factors or fee schedules in determining the amounts to be paid by the State of Arizona for doctors' services provided under various state programs. Information concerning the relative value schedules, unit conversion factors or fee schedules which might have been used or referred to by such state agencies, departments and programs may be ascertained or derived from the documents produced by plaintiff for inspection and copying by defendants pursuant to plaintiff's Supplemental Response to Defendant Maricopa Foundation for Medical Care's First Request for Production and Tangible Things, and the additional documents which plaintiff has previously made available for inspection and copying by defendants.

INTERROGATORY NO. 24

Identify each and every person within the definition of "State" who has participated at any time in the preparation, establishment, maintenance, revision or stabilization of any (a) relative value schedule; (b) unit conversion factor; or (c) fee schedule.

RESPONSE

Without waiving or intending to waive any objection with respect thereto, plaintiff responds as follows:

With respect to the schedule setting out maximum allowable fees which the Department of Economic Security deems reasonable for services provided by the Department

pursuant to Ariz. Rev. Stat. Ann. § 8-512, Ms. Alice McLain, Administrator of the Comprehensive Medical and Dental Program for Foster Children of the Arizona Department of Economic Security;

With respect to the fee schedule prepared and adopted by the Industrial Commission of Arizona for doctors' services to injured employees under the Workmen's Compensation Program of Arizona pursuant to Ariz. Rev. Stat. Ann. § 23-908(B), the members of the Industrial Commission of Arizona and the Executive Director and staff of the Industrial Commission of Arizona;

With respect to the other agencies, departments and programs of the State of Arizona which may have used or referred to any relative value schedule, unit conversion factor or fee schedule in determining the amounts to be paid by the State of Arizona for doctors' services provided under various State programs, the information sought may be ascertained or derived in part from the documents produced by plaintiff for inspection and copying by defendants pursuant to plaintiff's Supplemental Response to Defendant Maricopa Foundation for Medical Care's First Request for Documents and Tangible Things, and the additional documents which plaintiff has previously made available for inspection and copying by defendants.

INTERROGATORY NO. 25

Describe each relative value schedule, unit conversion factor and fee schedule used by the State of Arizona and with respect to each (a) identify who used it; (b) state the time period during which it was used; (c) state the manner in which it was used; and (d) state the purpose for which it was used.

RESPONSE

Without waiving or intending to waive any objection with respect thereto, plaintiff answers as follows:

Plaintiff incorporates herein the information provided in plaintiff's answers to Interrogatories Nos. 22, 23, and 24 and further states that the information sought by Interrogatory No. 25 may be ascertained or derived in part from the documents produced by plaintiff for inspection and copying by defendants pursuant to plaintiff's Supplemental Response to Defendant Maricopa Foundation for Medical Care's First Request for Documents and Tangible Things, and from the additional documents which plaintiff has previously made available for copying and inspection by defendants.

INTERROGATORY NO. 26(a)

Set forth each and every method, procedure or process by which the State of Arizona purchases or otherwise obtains (a) health services . . . .

RESPONSE

Without waiving or intending to waive any objection with respect thereto, plaintiff answers as follows with respect to doctors' services:

The State of Arizona Department of Economic Security purchases or otherwise obtains doctors' services provided under the Comprehensive Medical and Dental Program for Foster Children pursuant to Ariz. Rev. Ann. § 8-512.

The Industrial Commission of Arizona purchases or otherwise obtains doctors' services provided to injured employees under the Workmen's Compensation Program of the State of Arizona pursuant to Ariz. Rev. Stat. Ann. § 23-908.

The Arizona Department of Corrections purchases doctors' services on a contract basis, as reflected in the documents of that Department produced by plaintiff pursuant to plaintiff's Supplemental Response to Defendant Maricopa Foundation for Medical Care's Request for Documents and Tangible Things.

The Arizona Department of Health Services provides doctors' services at the Crippled Children's Hospital on the basis of contracts executed with individual doctors by that Department, as reflected in the documents which plaintiff will produce for inspection and copying by defendants pursuant to plaintiff's Supplemental Response to Defendant Maricopa Foundation for Medical Care's First Request for Documents and Tangible Things.

The methods, procedures or processes by which certain other agencies, departments and programs of the State of Arizona purchase or otherwise obtain doctors' services may be derived or ascertained from the documents produced by plaintiff for inspection and copying by defendants pursuant to plaintiff's Supplemental Response to Defendant Maricopa Foundation for Medical Care's First Request for Documents and Tangible Things, and the additional documents which plaintiff has previously made available for inspection by defendants.

INTERROGATORY NO. 29 (a)

Set forth each and every method, procedure or process by which the State of Arizona selects providers, suppliers and sellers of (a) health services . . . .

RESPONSE

Without waiving or intending to waive any objection with respect thereto, plaintiff answers with respect to services, goods and products sold by doctors as follows:

The doctors who supply or sell services, goods and products provided by the State of Arizona through (a) the Comprehensive Medical and Dental Program for Foster Children administered by the Arizona Department of Economic Security, (b) the Workmen's Compensation Program administered by the Industrial Commission of Arizona, (c) the Sickle Cell Anemia Program administered by the Arizona Department of Health Services, (d) the Adult Cystic Fibrosis Program administered by the Arizona Department of Health Services, (e) the Indo-Chinese Refugee Medical

Assistance Program administered by the Arizona Department of Health Services, (f) the Day Care Program administered by the Arizona Department of Health Services, (g) the Veneral Disease Control Program administered by the Arizona Department of Health Services, (h) the Tuberculosis Control Program administered by the Arizona Department of Health Services, are selected by the individuals covered by those programs on an individual basis.

The doctors who supply or sell services, goods and products provided by the State of Arizona at the Crippled Children's Hospital are selected in accordance with the By-Laws of that Hospital, which will be produced by plaintiff for inspection and copying by defendant pursuant to plaintiff's Supplemental Response to Defendant Maricopa Foundation for Medical Care's First Request for Documents and Tangible Things.

The doctors who supply or sell services, goods and products provided by the State of Arizona Department of Corrections are selected on a contract basis as reflected by the documents produced by plaintiff with plaintiff's Supplemental Response to Defendant Maricopa Foundation for Medical Care's First Request for Documents and Tangible Things.

The methods, procedures or processes by which the State of Arizona selects the doctors who supply or sell services or goods and products provided by the State of Arizona through various programs administered by the Department of Economic Security and the Department of Health Services can be derived or ascertained from the documents which plaintiff will produce for inspection and copying by defendants pursuant to plaintiff's Supplemental Response to Defendant Maricopa Foundation for Medical Care's First Request for Documents and Tangible Objects.

INTERROGATORY NO. 32

Identify each and every person who provides, supplies or sells (a) health services . . . to the State of Arizona.

RESPONSE

Without waiving or intending to waive any objection with respect thereto, plaintiff answers with respect to the services, goods and products sold by doctors to the State of Arizona that the identity of the doctors who supply or sell such services may be derived or ascertained in part from the documents which plaintiff has produced and will produce for inspection and copying by the defendants pursuant to plaintiff's Supplemental Response to Defendant Maricopa Foundation for Medical Care's First Request for Documents and Tangible Objects, and the additional documents which plaintiff has previously made available for inspection and copying by defendant Maricopa Foundation.

(Signature and notary clause omitted in printing.)

Filed - JUL 18, 1979
W. J. Furstenau, Clerk
U. S. District Court
For The District of Arizona

(Caption omitted in printing.)

MEMORANDUM AND ORDER

Defendants Maricopa Foundation for Medical Care and Pima Foundation for Medical Care have moved to vacate the order of the Court dated April 30, 1979, which continued until further order the temporary restraining order contained in Paragraph 6 of the order dated November 2, 1978. The defendats have established irreparable injury to themselves by substantiating without dispute through affidavits that participating physicians have threatened to withdraw from the defendant foundations. The plaintiff, on the other hand, has failed to show injury to itself and those it represents that cannot be compensated by money damages or that could be avoided if the motion to vacate the temporary restraining order were denied. The plaintiff has also not demonstrated that the injury to it in granting the motion exceeds that incurred by defendants in denying the motion. The plaintiff, moreover, has not shown that it is likely to succeed on the merits based on the Rule-of-Reason approach adopted here, which requires relatively complex factual inquiries. Thus, whether treated as a motion to va-

cate the temporary restraining order, or, because of the lapse of time and the preparation of the parties, as an application for a preliminary injunction, the defendants are entitled to relief. Therefore,

IT IS ORDERED:

The defendants' motion to vacate the April 30, 1979, temporary restraining order is granted.

DATED July 17, 1979.

/s/
United States District Judge

Filed - JUL 19, 1979
W. J. Furstenau, Clerk
U. S. District Court
For The District of Arizona

(Caption omitted in printing.)

NOTICE OF APPEAL

NOTICE IS HEREBY GIVEN that the STATE OF ARIZONA, plaintiff above named, hereby appeals to the United States Court of Appeals for the Ninth Circuit from the order granting defendants' motion to vacate the April 30, 1979 temporary restraining order which was entered in this action on July 17, 1979.

DATED: July 19, 1979

(Signature omitted in printing)

Filed - JUL 23, 1979
W. J. Furstenau, Clerk
U. S. District Court
For The District of Arizona

(Caption omitted in printing.)

DEFENDANT MARICOPA FOUNDATION FOR MEDICAL CARE'S RESPONSE TO PLAINTIFF'S MOTION FOR SUMMARY JUDGMENT AND PERMANENT INJUNCTION

Preliminary Statement

Defendant Maricopa Foundation for Medical Care ("Maricopa Foundation") submits this memorandum in opposition to plaintiff's motion for summary judgment and permanent injunction.

By its Memorandum and Order dated June 5, 1979 at 12, the Court held that "there is insufficient evidence as to the *purpose* and *effect* of [defendants'] allegedly unlawful practices and the *power* of the defendants" upon which to base a motion for summary judgment in plaintiff's favor under the Rule of Reason. (emphasis added) The Court therefore denied plaintiff's Motion for Partial Summary Judgment on the Issue of Liability "with leave to file a similar motion based on *additional evidence* if appropriate." (emphasis added) *Id.* at 13.

Plaintiff's present motion for summary judgment is inappropriate, since (1) it relies on virtually no evidence that was not before the Court at the time it considered plain-

tiff's motion for partial summary judgment* and (2) it appears to be an attempt to obtain a final determination before Maricopa Foundation obtains the discovery to which it is entitled. Because plaintiff's present motion disregards the Court's instructions in its Memorandum and Order dated June 5, 1979 and is patently without merit, (as more fully set forth below), Maricopa Foundation respectfully prays that the Court deny the motion and award Maricopa Foundation its reasonable attorneys' fees incurred in responding to yet another of plaintiff's unnecessary and premature motions.

Argument

A. PLAINTIFF'S MOTION FOR SUMMARY JUDGMENT SHOULD BE DENIED BECAUSE THOSE "FACTS" UPON WHICH PLAINTIFF RELIES EITHER LACK EVIDENTIARY SUPPORT OR ARE CONTROVERTED BY MARICOPA FOUNDATION.

Under the Rule of Reason, the Supreme Court has long held that "[t]he true test of legality is whether the restraint imposed is such as merely regulates and perhaps thereby promotes competition or whether it is such as may suppress or even destroy competition." *Board of Trade of Chicago v. United States*, 246 U.S. 231, 38 S.Ct. 242, 244 (1918). *Accord National Soc'y of Professional Engr's v. United States*, 98 S.Ct. 1355, 1364-65 (1978). In order to determine

*The only additional "evidence" upon which plaintiff relies is the affidavit of Alice McClain attesting that appended competitive bids with respect to providing administrative services for the Comprehensive Medical and Dental Program for Foster Children of the State of Arizona are records maintained in the normal course of business. Significantly, those bids (one of which is that of Maricopa Foundation) fall within Maricopa Foundation's discovery request. Rather than producing them in the course of discovery as promised during the Local Rule 42A Conference held June 21, 1979, plaintiff appended the responsive documents as exhibits to its motion for summary judgment. It was not until a full week later that these responsive documents were produced to Maricopa Foundation, *subject to plaintiff's continuing objection that they were irrelevant.*

whether an activity promotes or suppresses competition the Court must examine a number of discrete factual questions. In *Board of Trade of Chicago v. United States*, 246 U.S. 231, 38 S.Ct. 242 (1918), the Court held that the district court had erred in excluding evidence with respect to the history and purpose of the defendant's "call rule" (whereby exchange members were prohibited from purchasing or offering to purchase grain "to arrive" after close of bidding at a price other than the closing bid) and stated:

> "[T]he court must ordinarily consider the facts peculiar to the business to which the restraint is applied; its condition before and after the restraint was imposed; the nature of the restraint and its effect, actual or probable. The history of the restraint, the evil believed to exist, the reason for adopting the particular remedy, the purpose or end sought to be attained, are all relevant facts."

38 S.Ct. at 244.

Consistent with *Chicago Board of Trade* this Court, by its June 5, 1979 Memorandum and Order, directed that similar evidence be adduced by the parties by which to determine whether the challenged activities of Maricopa Foundation violate the federal and state antitrust laws. Rather than complying with the Court's directive, plaintiff has submitted a motion for summary judgment based upon purportedly undisputed "facts" drawn from the same record that was before the Court when it denied plaintiff's earlier motion for summary judgment. Moreover, as Appendix A hereto reflects, "facts" asserted by plaintiff pertaining to material areas of inquiry required under a Rule of Reason analysis are virtually unsupported by the record and constitute nothing more than plaintiff's conclusory allegations. Plaintiff's interposing of a motion for summary judgment at this juncture, therefore, can only be viewed as an attempt to preclude Maricopa Foundation

from obtaining relevant discovery.*

Maricopa Foundation controverts plaintiff's purported factual assertions and will demonstrate at trial that its comprehensive medical insurance program provides a competitive alternative to third party payors (and through them to the public) that directly promotes rather than suppresses competition. Contrary to plaintiff's bald assertions, third party payors are free to underwrite or refuse to underwrite a Maricopa Foundation plan. Maricopa Foundation simply offers its program as one of many alternatives that a third party payor may choose to underwrite. [Affidavit of Anthony D. Mitten, dated November 17, 1978 appended to Maricopa Foundation's Motion to Dismiss the Compaint "Mitten Aff.", para.2] In many instances, a Maricopa Foundation plan is offered by employers to their employees as an alternative that they may accept or reject in favor of another plan of insurance. Illustrative is the City of Phoenix which offers its employees their choice of the Maricopa Foundation plan, the Arizona Health Plan and the Arizona Blue Cross Health Maintenance Organization.

In addition, member physicians are free to participate simultaneously in insurance programs other than that of Maricopa Foundation and to provide services to patients directly or through third party payors or any other basis that the physicians and the persons to whom they are providing services choose. [Mitten Aff. para. 4] In any event, participation in Maricopa Foundation does not affect the billings of member physicians to their patients. [*Id.*, para. 3] If Maricopa Foundation is eliminated as a competitor to

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*Immediately upon receiving this Court's Memorandum and Order dated June 5, 1979, Maricopa Foundation requested plaintiff both by telephone and by letter to commence fulfilling its discovery obligations to Maricopa Foundation. It was not until July 13, 1979 (one week after plaintiff filed its present motion for summary judgment) that plaintiff responded to Maricopa Foundation's interrogatories and document demands. Those responses were not only incomplete, but were replete with objections as to the relevancy of the discovery sought by Maricopa Foundation.

closed panel health maintenance organizations and other prepaid insurance programs, those remaining competitors may have less of an incentive to provide low cost, yet comprehensive medical care to consumers. The competitive impact of Maricopa Foundation insurance programs is indisputably a material factual issue that is yet to be determined.

Whether there are less restrictive means by which Maricopa Foundation may obtain its twin objectives of promoting fee-for-service medical care while providing the most comprehensive medical insurance at a competitive cost* is also a factual question which is at issue and must be determined. The Court should not accept plaintiff's unsupported conclusion that less retrictive alternatives exist. Plaintiff's very assertion of its contention compels the conclusion that the industry in which Maricopa Foundation competes must be examined in order to determine whether a less restrictive alternative in fact exists by which Maricopa Foundaiton can achieve its purposes. That determination, in turn, requires presentment of evidence pertaining to the impact of Maricopa Foundation's practices. Plaintiff's purported reliance upon pricing data, although actual price information is notably absent from plaintiff's papers, further buttresses the conclusion that competent evidence of impact is required under a Rule of Reason analysis.

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*Plaintiff asserts that Maricopa Foundation's purpose of "promot[ing] the interests of fee for service medicine . . ." [Plaintiff's Motion for Summary Judgment and Permanent Injunction "Plaintiff's Motion" at 5], demonstrates anticompetitive purpose. On its face, the preservation of competitive alternatives in an industry should be deemed to be consistent with the objectives of the antitrust laws. Indeed, the uncontroverted affidavit of Anthony D. Mitten establishes that "Maricopa Foundation was established to provide residents of Maricopa County with a competitive alternative to utilization of closed panel prepaid health insurance plans." [Mitten Aff. para. 2]

Because material issues of fact are yet to be determined, plaintiff's motion for summary judgment should be denied.

B. THE RULE OF REASON PRECLUDES THE GRANTING OF SUMMARY JUDGMENT SINCE MATERIAL FACTS WITH RESPECT TO MARICOPA FOUNDATION'S PURPOSE, ITS POWER AND THE EFFECT OF ITS CHALLENGED ACTIVITIES ARE IN DISPUTE.

Summary judgment is particularly inappropriate here because complex, disputed facts must be evaluated by the Court under a Rule of Reason analysis. Indeed, by its Memorandum and Order filed July 18, 1979 at 2, the Court held, on a record virtually identical to that presently before it, that "plaintiff . . . has not shown that it is likely to succeed on the merits based on the Rule of Reason approach adopted here, which requires relatively complex factual inquiries." Moreover, the very cases which plaintiff claims entitle it to summary judgment under the Rule of Reason amply demonstrate that that standard mandates detailed factual determinations by a trier of fact with respect to the purpose and impact of the alleged restraint and the power of the defendant imposing it. Illustrative are *Mackey v. National Football League*, 543 F.2d 606, 609 (9th Cir. 1976) (injunction issued only after 55 days of trial that produced a transcript in excess of 11,000 pages); *Smith v. Pro Football, Inc.*, 593 F.2d 1173, 1183 n.46 (D.C. Cir. 1978) (2,000 page record of detailed facts consisting, *inter alia*, of the history of the professional football industry); *Northern California Pharmaceutical Ass'n v. United States*, 306 F.2d 379, 391 (9th Cir. 1962) (over 1,000 pages of trial transcript in criminal proceeding for violation of Section 1 of the Sherman Act); *Plymouth Dealers' Ass'n v. United States*, 279 F.2d 128, 129 (9th Cir. 1960) (trial to jury under *per se* standard); *United States v. Utah Pharmaceutical Ass'n*, 201 F. Supp. 29, 30 (D. Utah 1962) (judgment against defendant, under *per se* standard, only after trial to the court

even though most of the facts had been stipulated by the parties).*

The only case cited by plaintiff in which summary judgment was entered under the Rule of Reason involved a discretionary restraint on employment that was neither limited as to time or extent.** *Kapp v. National Football League*, 390 F. Supp. 73, 82 (N.D. Cal. 1974), *aff'd*, 586 F.2d 644 (9th Cir. 1978). In granting summary judgment with respect to certain restrictive rules, the district court stated:

> "In applying the reasonableness test we have in mind that the issue of reasonableness is *ordinarily* in such genuine dispute that a case cannot be resolved on a motion for summary judgment." (emphasis added)

390 F. Supp. at 82. While some of the restrictive rules were "patently unreasonable" because they would "*perpetually* restrain a player from pursuing his occupation among the clubs of a league that holds a virtual monopoly of profes-

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*The case upon which plaintiff places primary reliance to its entitlement to summary judgment, *United States v. Southern Motor Carriers Rate Conference, Inc.*, 467 F. Supp. 471 (N.D. Ga. 1979), did not, as plaintiff represents, grant summary judgment under the Rule of Reason. In fact, after granting summary judgment under the *per se* rule, the court merely intimated, "[n] or would we *necessarily* reach a different result under rule of reason analysis. . . . The focus would continue to be on the *effect* of collective rate-making on price competition among intrastate carriers." *Id.* at 486-87 n.11 (emphasis added).

**Plaintiff additionally cites *Associated Press v. United States*, 326 U.S. 1 (1945) and *Silver v. New York Stock Exch.*, 373 U.S. 341 (1963) in which summary judgments were granted. Both cases, however, involved concerted refusals to deal in which the underlying facts were undisputed. Moreover, notwithstanding plaintiff's mercurial shift from its characterization of third party payors as co-conspirators [Complaint, para. 9] to victims of the defendants' newly-alleged concerted refusals to deal, there is no factual support whatsoever for plaintiff's most recent theory. *See* Appendix A attached hereto. *Silver* is further inapposite because the Court analyzed the facts under a *per se* standard, rejecting any defense of reasonableness derived from compliance with SEC rules because the challenged practice on its face clearly exceeded the purposes of the Securities Exchange Act. 373 U.S. at 365.

sional football employment in the United States" and because they "permit[] virtually *perpetual* boycott . . ." the court refused to grant summary judgment with respect to the reasonableness of the "option rule" that left the matters of duration of contracts and salary to free negotiation between players and clubs. *Id.* at 82-83 (emphasis in original).

Similarly, summary judgment is inappropriate here because physicians specifically agree that "participating membership in the Foundation shall not affect the method of computation or amount of fees billed by me with respect to any medical care for any patient."* Member physicians clearly are free, unlike National Football League players, to negotiate either with third party payors or with non-Maricopa Foundation insured patients as to the compensation that they will receive from them for services rendered. Third party payors are similarly free to underwrite or refuse to underwrite Maricopa Foundation plans. Patients, too, (including those insured under Maricopa Foundation-endorsed insurance plans) may seek either the services of member of non-member physicians. In either case, the third party payor will pay to the provider up to Maricopa Foundation's maximum level of reimbursement.** [Mitten Aff. para. 4] In the case of a Maricopa Foundation member, however, since he has agreed in advance to accept the Maricopa Foundation level of reimbursement as full compensation, he is precluded from billing the patient for the balance of his normal charge. A non-member, of course, may bill the patient to the extent that the Maricopa Foundation maximum level does not fully reimburse him. On their face, Maricopa Foundation's activities do not in any sense impede free negotiation in the market. At a minimum, the impact of the practices is in clear dispute.

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*Mitten Aff. para. 3 and Exhibit A thereto.

**Those physicians who charge less than Maricopa Foundation's maximum level of reimbursement receive payment only to the extent of their actual charges. [Mitten Aff. para. 4]

Plaintiff's reliance upon the mere circulation of relative value guides and conversion factors to support its entitlement to summary judgment is similarly insufficient. The State itself engages in the same activities through the Department of Economic Security and the Industrial Commission of Arizona.* While the Supreme Court in *Goldfarb v. Virginia State Bar*, 421 U.S. 773 (1975) held that a mandatory minimum fee schedule with respect to the prices to be charged for legal services violated Section 1 of the Sherman Act, there is no proof of uniform pricing here.** The Supreme Court said:

> "A purely advisory fee schedule issued to provide guidelines, or an exchange of price information without a showing of an actual restraint or trade, would present us with a different question . . .
>
> * * * *
>
> The fact that a restraint operates upon a profession as distinguished from a business is, of course, relevant in determining whether that particular restraint violates the Sherman Act."

421 U.S. at 781, 788 n.17.

Plaintiff has presented no factual support for its claim that Maricopa Foundation's maximum level of reimbursement either is intended to be an advisory fee schedule or has operated as such. There is no evidence of any coercion to force adherence in billing to Maricopa Foundation's maximum reimbursement levels. Indeed, there is no evidence of any

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*Supplemental Responses 22 through 25 of the State of Arizona to Defendant Maricopa Foundation for Medical Care's First Set of Interrogatories.

**See illustratively exhibits 1 through 4 attached to Appendix A hereto which clearly reflect the disparity in prices charged by Maricopa Foundation members for services rendered in connection with four common surgical procedures.

effort to encourage any doctors to change any price for a medical service. Instead, plaintiff relies entirely on theoretical hypotheses from law review articles unsupported by any facts.

Plaintiff's further argument with respect to the anticompetitive nature of relative value guides is totally misplaced. To support its contention that relative value guides in and of themselves are anticompetitive, plaintiff relies upon irrelevant and immaterial consent decrees, none of which adjudicated the legality of the relative value guides. Illustrative is the Settlement Agreement entered in connection with *Ohio v. Ohio Medical Indemnity, Inc.*, CIV No. C-2-75-473 (S.D. Ohio), a copy of which is appended to plaintiff's motion:

> "Nothing herein shall constitute an adjudication, determination or finding of fact or law relative to any issue raised in this cause nor shall this Dismissal Order constitute evidence against, or an admission by, any party . . ."

[Dismissal Order appended as Appendix C to Settlement Agreement, para. 5] Moreover, in the only decision to date pertaining to the dissemination and use of relative value guides, *United States v. American Soc'y of Anesthesiologists, Inc.*, No. CIV 4640 (KTD) (S.D.N.Y., filed June 21, 1979), the Court denied plaintiff the relief it sought holding that:

> "[T]he guides facilitated the interchange between insurance carriers and physicians . . .
>
> * * * *
>
> When viewed in the context of this unusual market, it would seem that *defendant's activities tended to promote the interplay of such competitive forces as existed in the area* . . ." (emphasis added)

[Slip. Op. at 37-38]

In view of the Supreme Court's intimation in *Goldfarb v. Virginia State Bar* and the holding in *United States v. American Soc'y of Anesthesiologists, Inc.* that dissemination and use of the Anesthesiology Relative Value Guide (which Maricopa Foundation uses in part)*[1] does not violate the antitrust laws and is in fact, procompetitive, Maricopa Foundation rather than plaintiff is more properly entitled to summary judgment, if any such judgment could be granted. In any event there is insufficient evidence upon which to base a Rule of Reason determination in plaintiff's favor and many of the supposed facts upon which plaintiff relies are controverted by Maricopa Foundation. Not only has plaintiff not shown entitlement to summary judgment, but for all the reasons set forth in the Memorandum in Support of Defendant Maricopa Foundation for Medical Care's Motion to Vacate Temporary Restraining Order of April 30, 1979, which is incorporated herein by reference, plaintiff has failed to show any entitlement to injunctive relief.*[2] Therefore, Maricopa Foundation respectfully submits that plaintiff's motion for summary judgment and permanent injunction be denied in its entirety.

July 23, 1979

(Signatures omitted in printing.)

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*[1] As does the State of Arizona itself through its Industrial Commission. *See* "Medical Fee Schedule" adopted by The Industrial Commission of Arizona, December 1, 1970, Appendix I.

*[2] Plaintiff's request for "an order specifying the issues of law . . . which remain to be tried . . ." [Plaintiff's Motion at 41] reflects its habitual overreaching. Rule 56(d) provides only that a court "shall, if practicable ascertain what material facts exist without substantial controversy and what material facts are actually in good faith controverted. It shall thereupon make an order specifying the facts that appear without substantial controversy . . ."

APPENDIX A

Illustrative Conclusory Statements Asserted by Plaintiff as "Facts" that Are Unsupported by the Record

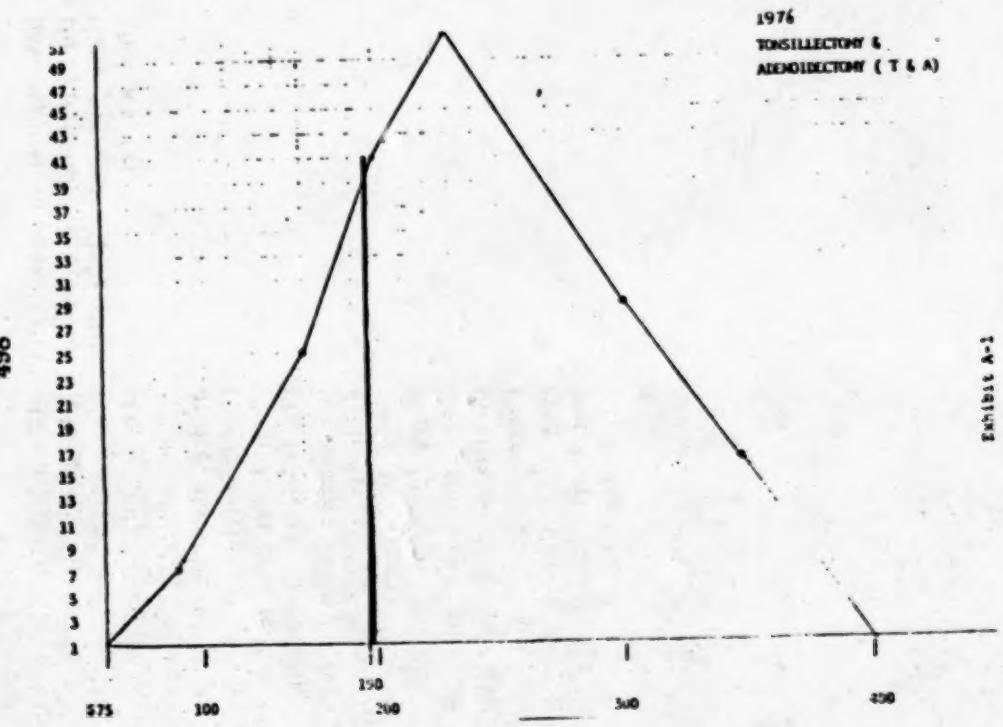
PLAINTIFF'S ALLEGATION	PLAINTIFF'S SUBSTANTIATION
A. Power.	
"[E]ach fee-for-service physician possesses a significant degree of natural monopoly power . . ." [Plaintiff's Motion at 19, 20]	No factual support, relies upon Havighurst, "Health Maintenance Organizations and the Market for Health Services," 35 *Law and Contemp. Prob.* 716, 768 (1970)
"It is therefore, no exaggeration to state that defendant trade associations [the Foundations] . . . are in effect combinations of monopolists with unique power as sellers in the marketplace."	No factual support.
B. Effect.	
"[T]he Court is presented with an agreement among competitors not to discuss prices at all with third part payors . . ." [Plaintiff's Motion at 20]	No factual support.
"[T]hird parties that underwrite foundation-approved plans have had no vote whatsoever on the professional fees they must pay under those plans." [Plaintiff's Motion at 24]	No factual support.

"By setting a cartel price for the services they provide to insured persons, the foundations' member doctors have directly restricted independent pricing of doctors' services and have curtailed the bargaining power which third party payors might have exercised in the absence of a doctors' cartel. "[Plaintiff's Motion at 22]	No factual support; relies only upon Havighurst, *supra*.
"[The defendants' purported horizontal price fixing] is a direct and severe restraint on the bargaining power of the insurer in negotiating reimbursement schedules with fee-for-service physicians." [Plaintiff's Motion at 26]	No factual support.
"The procedures by which the defendants have maintained and revised those fee schedules through widespread price surveys and price agreements ... have clearly been intended to result in agreed-upon price levels for doctors." [Plaintiff's Motion at 27]	No factual support.
"Defendants have made it clear that the fee schedules they have proposed to their members for adoption represented a consensus on the prices which doctors in the community *would* be charging in the period after the fee	No factual support.

schedules were adopted . . ." (emphasis added) [Plaintiff's Motion at 28]	
"[Defendants'] uniform fee schedules and fee increases . . . have suppressed the individual pricing of medical services by fee-for-service doctors and third payors." [Plaintiff's Motion at 19]	No factual support, stating instead that "No elaborate analysis is needed to discern the anticompetitive impact of such conduct."
"[T]he foundations' uniform fee schedules have led to uniform pricing . . ." [Plaintiff's Motion at 16]	No factual support, stating, without citation to the record, that "85 to 95 percent of foundation members bill at or above the rates set in the foundation fee schedules." [Plaintiff's Motion at 16] Significantly, charts to which plaintiff may be referring [attached hereto as Exhibits 1-4] reflect a great disparity in the prices charged by physicians for professional services with respect to four typical surgical procedures.
"[A]fter an increase in the level of fees set in the foundation fee schedule has been adopted by the foundation members, overall doctors' fees have risen to that level." [Plaintiff's Motion at 16]	Maricopa Foundation RFA's 228-35 relied upon by plaintiff, do not support plaintiff's allegation; moreover the AMA and HIAA data cited has not been determined to be either statistically competent or admissible.
"[T]he agreed upon increases in defendants' fee schedules	The record cited [Maricopa Foundation's Responses to

have resulted in increases in the premiums charged on those plans." [Plaintiff's Motion at 14]

plaintiff's First Request for Admissions "RFA" and Interrogatories 143 & 224] reflect only that Maricopa Foundation sought actuarial advice. Moreover, the deposition transcript relied uon by plaintiff provides as follows: "In this case, [an insurance premium rate adjustment] evidently [followed an increase in Maricopa Foundation's Minimum Standards] . . . for this particular insurer for the Scottsdale School's Program, *but not for every program and every insured.*" (emphasis added) [Mitten Depo., Vol. 1 at 64]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ADENOIDECTOMY (T & A)
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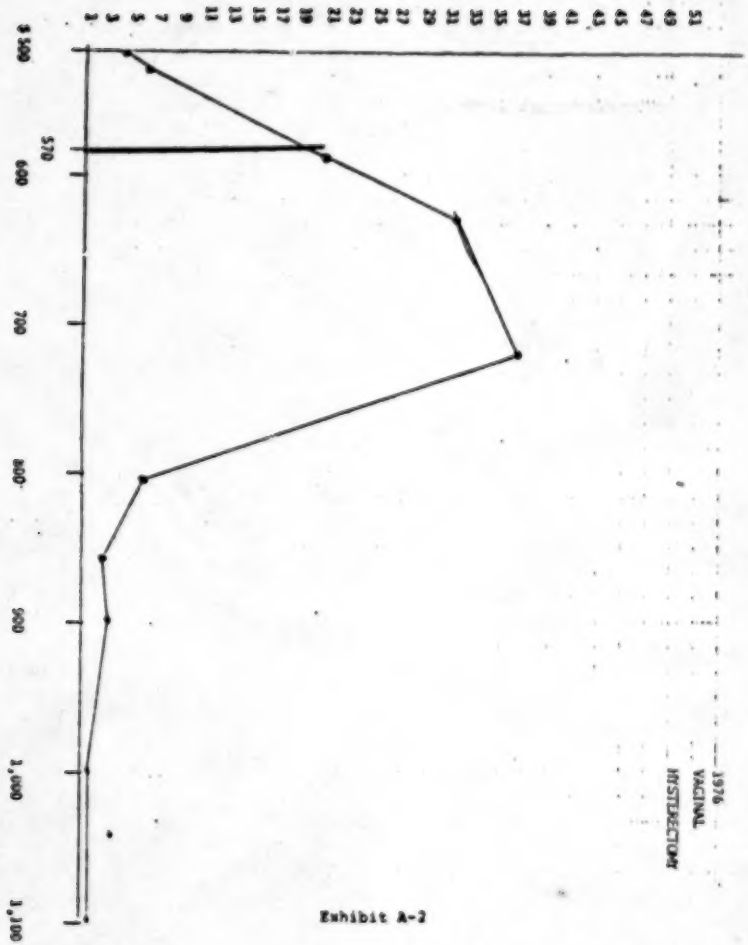
Exhibit A-1



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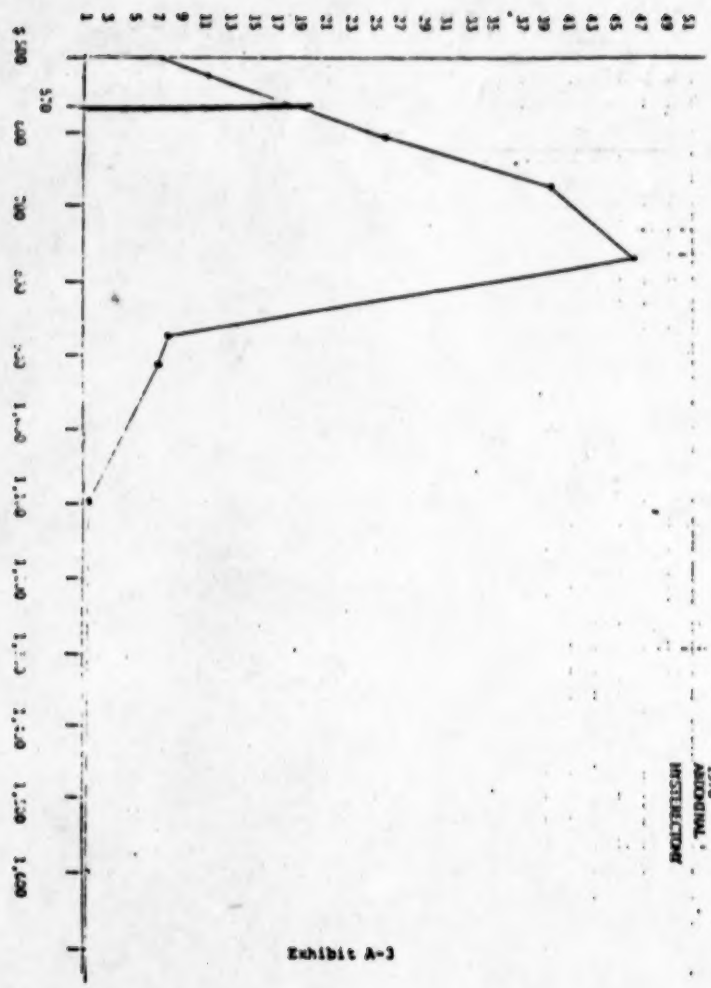

Exhibit A-3

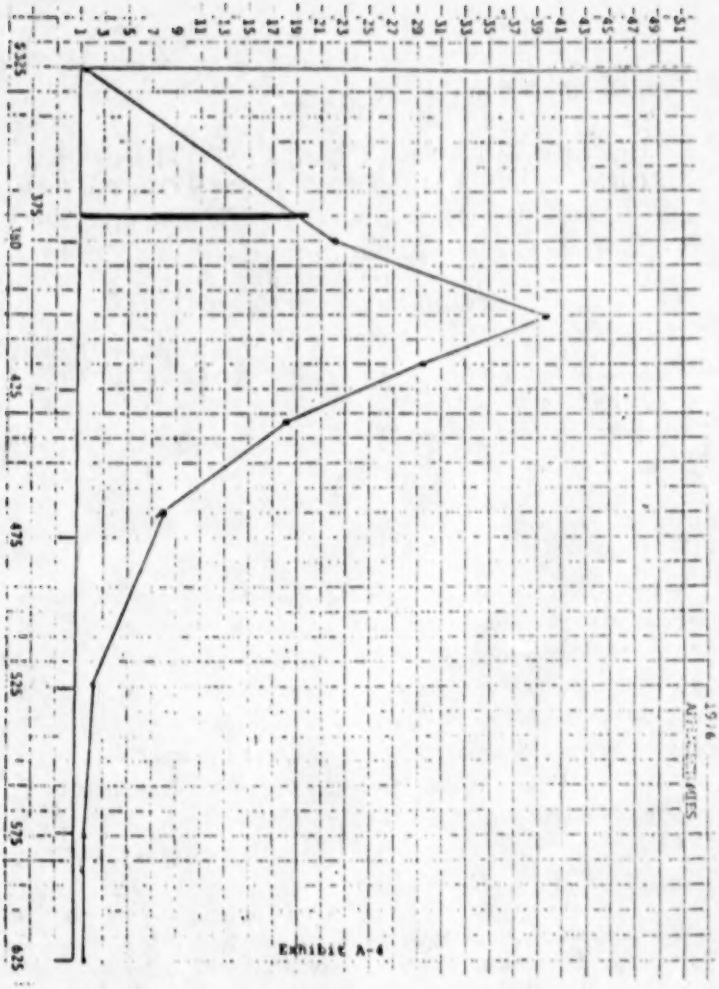
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Exhibit A-4

Filed - JUL 23, 1979
W. J. Furstenau, Clerk
U. S. District Court
For The District of Arizona

(Caption omitted in printing.)

DEFENDANT MARICOPA FOUNDATION FOR MEDICAL CARE'S MEMORANDUM IN OPPOSITION TO PLAINTIFF'S MOTION FOR RECONSIDERATION OF MEMORANDUM AND ORDER OF JUNE 5, 1979

Preliminary Statement

This memorandum is submitted by defendant Maricopa Foundation for Medical Care ("Maricopa Foundation") in opposition to plaintiff's Motion for Reconsideration of Memorandum and Order of June 5, 1979, or, Alternatively, Motion for Certification for Interlocutory Appeal Pursuant to 28 U.S.C. § 1292(b) of Memorandum and Order of June 5, 1979.*[1]

In support of its motions, plaintiff has provided the Court with a lengthy—albeit inaccurate—review of antitrust law and a totally misleading characterization of what plaintiff contends are uncontroverted facts;*[2] plaintiff has not, however, provided the Court with any new arguments or intervening developments that might properly form the basis of a motion for reconsideration. Instead, plaintiff simply rehashes arguments already advanced and rejected by the Court in determining that the Rule of Reason standard

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*[1] Because plaintiff's motion for reconsideration seeks to renew its motion for partial summary judgment on the issue of liability, Maricopa Foundation incorporates herein its previously filed Statement of Material Facts as to Which There Is a Genuine Issue Precluding Summary Judgment in Favor of the Plaintiff on the Issue of Liability (December 11, 1978).

*[2] Those "facts" are dealt with in Maricopa Foundation's Response to Plaintiff's Motion for Summary Judgment and Permanent Injunction (July 23, 1979).

should govern the resolution of this case.** The burden on Maricopa Foundation in being forced to respond to these meritless motions is unjustifiable; it constitutes harrassment of Maricopa Foundation, and an unwarranted imposition on the resources of the Court.*** Therefore, Maricopa Foundation submits that the motions should be denied, that Maricopa Foundation should be awarded its reasonable attorneys' fees and that the Court should impose such further sanctions as it may deem appropriate.

Plaintiff's motion for reconsideration rests upon a fundamental misapprehension as to applicable law and a sweeping disregard of the facts in this case. In its Memorandum and Order of June 5, 1979, the Court noted the undisputed fact that the doctors who agree to participate in the Foundation-approved plans are free to set the prices they charge their patients. (Memorandum and Order at 2.) The only thing to which any physician has agreed is that he or she will accept the maximum level of reimbursement applicable to Foundation-endorsed health insurance plans as payment in full for services provided to patients insured under such plans. *Id.*

Nevertheless, plaintiff again contends in its motion that it has established by uncontroverted evidence existence of a naked horizontal price-fixing conspiracy among competitors that should be declared *per se* illegal. (See, *e.g.*, Plaintiff's Motion for Reconsideration at 48.) In its Memorandum and Order of June 5, 1979, the Court properly declined plaintiff's invitation to place an improper, conclusory label on

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**The proper standard to be applied was an issue thoroughly briefed by the parties. See Maricopa Foundation for Medical Care's Memorandum in Opposition to Plaintiff's Motion for Partial Summary Judgment on the Issue of Liability (December 11, 1978); Reply Memorandum in Support of Plaintiff's Motion for Partial Summary Judgment on the Issue of Liability (December 21, 1978).

***Plaintiff continues its efforts to have the same questions decided over and over again. On July 19, 1979, plaintiff noticed an appeal from this Court's Order of July 17, 1979 granting Maricopa Foundation's Motion to Vacate Temporary Restraining Order of April 30, 1979.

Maricopa Foundation's conduct and then mechanically apply *per se* rules developed in other contexts to the acts of Maricopa Foundation. Plaintiff's present attack on the Court's decision cannot alter the appropriateness of the approach taken and the propriety of the conclusions reached therein.

Argument

A. THE COURT'S MEMORANDUM AND ORDER OF JUNE 5, 1979 CORRECTLY RECOGNIZED THAT THE FORMALISTIC APPROACH ARGUED FOR BY PLAINTIFF SHOULD BE REJECTED IN FAVOR OF A REASONED ANALYSIS OF THE CHALLENGED PRACTICES.

Concluding that the Rule of Reason was the proper analytical framework in which to examine Maricopa Foundation's conduct, this Court stated: "Although the per se approach avoids inquiry into difficcult economic issues, a recent antitrust trend appears to be emerging where the Rule of Reason is the preferred method of determining whether a particular practice is in violation of the antitrust laws." *Id.* at 7. This conclusion is in harmony with recent pronouncements of the Supreme Court that have eschewed antitrust analysis artifically divorced from the economic realities of the particular case.

In *Continental T.V., Inc. v. GTE Sylvania, Inc.*, 433 U.S. 36, 97 S. Ct. 2549 (1977), the Supreme Court, overruling its earlier decision in *United States v. Arnold, Schwinn & Co.*, 388 U.S. 365, 87 S. Ct. 1856 (1967), condemned the precipitous application of *per se* rules in antitrust cases. The Court noted that the *Schwinn* case itself "was an abrupt and largely unexplained departure from *White Motor Co. v. United States*, 372 U.S. 253, 83 S. Ct. 696, 9 L. Ed. 2d 738 (1963), where only four years earlier the Court had refused to endorse a *per se* rule for vertical restrictions." *Continental T.V., Inc. v. GTE Sylvania, Inc.*, 97 S. Ct. at 2556. In rejecting the truncated *per se* analysis employed in *Schwinn*, the Court plainly insisted that courts focus on the

substantive orientation of the antitrust laws in analyzing particular cases, declaring: "Realities must dominate judgment.... The Anti-Trust Act aims at substance." *Id.*, *quoting Appalachian Coals, Inc. v. United States*, 288 U.S. 344, 360 (1933). The Court emphasized that "[p]*er se* rules of illegality are appropriate only when they relate to conduct that is manifestly anti-competitive," 97 S. Ct. at 2558, and warned: "[W]e ... make clear that departure from the rule of reason standard must be based upon demonstrable economic effect rather than—as in *Schwinn*—upon formalistic line drawing." *Id.* at 2562. By applying conclusory labels to the practices here and arguing for a blind application of the *per se* rule with no showing of "demonstrable economic effect," plaintiff asks the Court to disregard this admonition.

More recently, in *Broadcast Music, Inc. v. Columbia Broadcasting*, 99 S. Ct. 1551 (1979), the Court again rejected the simplistic *per se* approach to antitrust analysis favored by plaintiff. Holding that the Rule of Reason should govern the determination of the legality of the blanket licensing practice at issue, (which had been held to be *per se* illegal price-fixing by the Court of Appeals), the Supreme Court observed that while the *per se* rule "is a valid and useful tool of antitrust policy and enforcement," courts must not be too quick to seize upon it as a replacement for reasoned analysis of challenged practices: "[E]asy labels do not always supply ready answers." *Id.* at 1556.

Plaintiff's rush to affix the label of horizontal price-fixing to Maricopa Foundation's practices stands at odds with the searching analysis mandated by *Broadcast Music:*

> To the Court of Appeals and CBS, the blanket license involves 'price fixing' in the literal sense: the composers and publishing houses have joined together into an organization that sets its price for the blanket license it sells. But this is not a question simply of determining whether two or more potential competitors have literally 'fixed' a 'price'. As generally used in the antitrust field, 'price fixing' is a shorthand way of de-

> scribing certain categories of business behavior to which the *per se* rule had been held applicable. The Court of Appeals' literal approach does not alone establish that this particular practice is one of those types or that it is 'plainly anticompetitive' and very likely without 'redeeming virtue.' Literalness is overly simplistic and often overbroad. . . .
>
> Consequently, '[i]t is only after considerable experience with certain business relationships that courts classify them as *per se* violations. . . .' [Citation omitted.]

Id. at 1557. The Supreme Court concluded that ["n]ot all arrangements among actual or potential competitors that have an impact on price are *per se* violations of the Sherman Act or even unreasonable restraints." *Id.* at 1564. The Foundation-endorsed insurance plans are, it is respectfully submitted, subject to the same analysis as "separate products" as the blanket licenses in the *BMI* case. As in *BMI*, plaintiff has failed to establish any agreement by competitors as to prices they will sell at on an individual basis.*

As this Court recognized in its Memorandum and Order of June 5, 1979, the Supreme Court has underscored the lack of utility from both a social and economic perspective of mechanical resort to the *per se* rule. This Court correctly stated that "[a]nother consideration in determining whether to apply the Rule of Reason approach is that a profession is involved here." (Memorandum and Order at 8-9.) The antitrust laws were not intended to straight-jacket imaginative experimentation in fields, such as the profes-

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*The Court noted that blanket licensing had produced "substantial lowering of costs, which is of course potentially beneficial to both sellers and buyers," *id.* at 1563, and that "[t]he individual composers and authors have neither agreed to not to sell individually in any other market nor use the blanket license to mask price fixing in such other markets." *Id.* at 1564. These very same factors are present here. Maricopa Foundation has maintained throughout these proceedings, and the record bears it out, that participating physicians have not agreed upon the fees to be charged patients and that Foundation-endorsed health insurance plans offer a lower cost alternative to other health insurance plans.

sions, not traditionally subject to antitrust scrutiny. Therefore, as this Court further noted, it is inappropraite to make a wholesale transfer of rules fashioned in a purely commercial context to activities involving professionals. (See *id.* at 8-12.)

In *National Soc'y of Professional Eng'rs v. United States*, 425 U.S. 679, 98 S. Ct. 1355 (1978), the Supreme Court cautioned that "certain practices by members of a learned profession might survive scrutiny under the Rule of Reason even though they would be viewed as a violation of the Sherman Act in another context." 98 S. Ct. at 1362.* *Goldfarb v. Virginia State Bar*, 421 U.S. 773, 788 n.17 (1975) ("It would be unrealistic to view the practice of professions as interchangeable with other business activities, and automatically to apply to the professions antitrust concepts which originated in other areas"); *Boddicker v. Arizona State Dental Ass'n*, 549 F.2d 626, 632 (9th Cir.), *cert. denied*, 434 U.S. 825 (1977) ("[T]he Supreme Court does not require that the practices challenged here be treated the same as would be proper if dentistry were merely a commercial enterprise"). This recognition of the professions as unsuited to the application of the same rules as commercial enterprises—together with the Supreme Court's expressed disfavor of unthinking *per se* analysis even in a commercial context. *Continental T.V., Inc. v. GTE Sylvania, Inc.; Broadcast Music, Inc. v. Columbia Broadcasting*—fully support this Court's determination that the Rule of Reason is the governing standard in this case.

Finally, the Supreme Court reiterated in *Broadcast Music, Inc. v. Columbia Braodcasting* that "[i]t is only after considerable experience with certain business relationships that courts classify them as *per se* violations." *Id.* at 1557. See *White Motor Co. v. United States*, 372 U.S. 253, 263,

*Despite this Court's decision, plaintiff stubbornly and incorrectly continues to contend that *Professional Engr's* was decided under a *per se* test.

(1963) ("We need to know more than we do about the actual impact of these arrangements on competition to decide whether they have a 'pernicious effect on competition and lack . . . any redeeming virtue' [citation omitted] and therefore should be classified as *per se* violations of the Sherman Act"). In fact, it was the sudden imposition of a *per se* rule by the *Schwinn* decision—only four (4) years after the Court in *White Motor Co.* refused to take that step—that so disturbed the Court in *Continental T.V., Inc. v. GTE Sylvania, Inc.*, 97 S. Ct. at 2556, 2558. The Court concluded that *Schwinn* had precipitously endorsed a *per se* rule for vertical restrictions. Similarly here, there has been too little antitrust experience with the foundation concept for offering a lower cost alternative health insurance plan to blindly apply, as would plaintiff, a rigid *per se* analysis in the present case and this Court was correct in refusing to do so.*

B. THE COURT'S JUNE 5, 1979 MEMORANDUM AND ORDER IS INAPPROPRIATE FOR CERTIFICATION PURSUANT TO 28 U.S.C. § 1292(b).

Plaintiff has moved the Court pursuant to 28 U.S.C. § 1292(b) to certify its Memorandum and Order of June 5, 1979, arguing that the question of whether practices challenged in this case should be analyzied under the "Rule of Reason" is a "controlling question of law as to which there is a substantial ground for difference of opinion and that an immediate appeal from the order may materially advance the ultimate termination of the litigation." 28 U.S.C. § 1292(b). Plaintiff's motion is unfounded as it is clear that no "substantial ground for difference of opinion" exists. In *Berger v. United States*, 170 F. Supp. 795 (S.D.N.Y. 1959),

*In fact, it has only been within the last four (4) years—since the decision in *Goldfarb v. Virginia State Bar*—that the antitrust laws were held by the Supreme Court to be applicable at all to professions. Given this short time span, application of the *per se* rule to a professional group, as plaintiff contends, would be precipitous, ill-advised and inappropriate.

the court stated that whether there is substantial ground for difference of opinion depends on whether the appellant "has a good enough chance of success so that its appeal ought to be given special treatment." 170 F. Supp. at 796. The court in *Berger* refused to certify its denial of a motion to dismiss for lack of jurisdiction because it foresaw no probability that its decision would be reversed. *Seven-Up Co. v. O-So Grape Co.*, 179 F. Supp. 167, 172 (S.D. Ill. 1959) (court denying certification under 28 U.S.C. § 1292(b) stated: "A question of law 'as to which there is substantial ground for difference of opinion' as that phrase is used in the statute, must be construed as synonymous with a substantial likelihood that appellant's position would prevail on appeal.").

In the present case, there is no substantial likelihood that this Court's decision to review Maricopa Foundation's conduct under the Rule of Reason will be reversed. The Supreme Court has recently stated that the Rule of Reason is "the standard traditionally applied for the majority of anticompetitive practices challenged under § 1 of the [Sherman] Act." *Continental T.V., Inc. v. GTE Sylvania, Inc.*, 97 S. Ct. at 2563. More specifically, the Supreme Court and the Ninth Circuit have both endorsed the Rule of Reason as the preferred method of analysis where the conduct allegedly violating the antitrust laws involves a profession. *national Soc'y of Professional Engr's v. United States; Boddicker v. Arizona State Dental Ass'n.* Under these circumstances, it can hardly be said that this Court has departed from established precedent or fashioned a new doctrine in a novel area. There is therefore no basis for concluding that the Court's Memorandum and Order of June 5, 1979 presents a question as to which there is "a substantial ground for difference of opinion."

Moreover, certification will not materially advance the ultimate termination of the litigation because under either the *per se* rule or Rule of Reason plaintiff cannot prevail on the facts. And it is the actual facts of the case that plaintiff continually ignores in repeatedly pressing for summary adjudication and now an interlocutory appeal.

Conclusion

For the foregoing reasons, plaintiff's motion for reconsideration or, alternatively, certification should be denied. Maricopa Foundation further submits that the Court should award Maricopa Foundation its reasonable attorney's fees for being forced to respond to these motions.

July 23, 1979

(Signatures omitted in printing.)

Filed - JUL 31, 1979
W. J. Furstenau, Clerk
U. S. District Court
For The District of Arizona

(Caption omitted in printing.)

DEFENDANT MARICOPA FOUNDATION FOR MEDICAL CARE'S STATEMENT OF MATERIAL FACTS AS TO WHICH THERE IS A GENUINE DISPUTE PRECLUDING SUMMARY JUDGMENT IN FAVOR OF THE PLAINTIFF

Defendant Maricopa Foundation for Medical Care ("Maricopa Foundation") submits, pursuant to Local Rule 11(h), this statement of material facts which preclude summary judgment in favor of the plaintiff.

A. Defendant Maricopa Foundation disputes plaintiff's contention that the following paragraphs of "Statement of Undisputed Facts Supporting Plaintiff's Motion for Summary Judgment and Permanent Injunction" are not disputed:*

1. With respect to plaintiff's Statement 1, the membership of Maricopa Foundation includes medical doctors, osteopaths, podiatrists and oral surgeons. Maricopa Foundation has no information sufficient to admit or deny plaintiff's Statement 1 with respect to the Pima Foundation for Medical Care ("Pima Foundation"), the Pima County Medical Society ("Pima Society") and the Maricopa County Medical Society ("Maricopa Society"). [Maricopa Foundation's Response to Plaintiff's First Request for Admissions and Interrogatories "RFA" 310, 311]

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*The Court should note that many of plaintiff's alleged "Undisputed Facts" were previously identified by Maricopa Foundation as being disputed in Defendant Maricopa Foundation for Medical Care's Statement of Material Facts as to Which There Is a Genuine Issue Precluding Summary Judgment in Favor of the Plaintiff on the Issue of Liability dated December 11, 1978. See *e.g.*, para. A.1. *id.*

2. With respect to plaintiff's Statement 2, Maricopa Foundation admits that from time to time during 1975 it informed Maricopa Society of some of its activities, but has no information sufficient to admit or deny that Maricopa Society or Pima Society approved of Maricopa Foundation's activities or that Pima Society knew of Maricopa Foundation's activities. Maricopa Foundation has no information sufficient to admit or deny plaintiff's Statement 2 with respect to knowledge or approval of Pima Foundation's activities by Maricopa Society or Pima Society.

3. With respect to plaintiff's Statement 3, Maricopa Foundation was founded by its membership, *inter alia*, to promote the practice of medicine in Maricopa County on a fee for service basis. [RFA 91, affidavit of Anthony D. Mitten sworn to November 17, 1978, para. 2] Maricopa Foundation has no information sufficient to admit or deny plaintiff's Statement 3 with respect to Pima Foundation, Pima Society or Maricopa Society.

4. Denies plaintiff's Statement 4 with respect to Maricopa Foundation and states as of February 1977, Maricopa Foundation's membership consisted of approximately 1,052 persons. [RFA 268] Maricopa Foundation has no information sufficient to admit or deny plaintiff's Statement 4 with respect to Pima Foundation, Pima Society, and Maricopa Society.

5. Maricopa Foundation has no information sufficient to admit or deny plaintiff's Statement 5.

6. With respect to plaintiff's Statement 6,* members of the Board of Directors of Maricopa Society are entitled to become administrative members of Maricopa Foundation; to qualify as a participating member of Maricopa Foundation, a physician must be licensed to practice medicine or osteopathy in Arizona; to qualify as a cooperating member of Maricopa Foundation, a doctor must be licensed

*Apparently the numerical designation for this paragraph was inadvertently omitted in plaintiff's papers.

to practice podiatry or oral surgery in Arizona. [RFA 3, 310, 311]

7. Maricopa Foundation has no information sufficient to admit or deny plaintiff's Statement 7.

8. Maricopa Foundation has no information sufficient to admit or deny plaintiff's Statement 8.

9. With respect to plaintiff's Statement 9, pursuant to the By-Laws of Maricopa Foundation, every person, upon becoming a member of the Board of Directors of the Maricopa Society, is entitled to become and, without further action or proceeding becomes an administrative member of Maricopa Foundation. [RFA 3]

10. With respect to plaintiff's Statement 10, pursuant to the By-Laws of Maricopa Foundation, its administrative members have the authority to elect by majority vote members of the Board of Trustees of Maricopa Foundation and have exercised that authority.

11. With respect to plaintiff's Statement 11, the By-Laws of Maricopa Foundation provide that the Executive Committee of Maricopa Foundation shall be composed of three or more participating members of Maricopa Foundation and that nine of the twelve members of Maricopa Foundation's Board of Trustees shall be participating members of Maricopa Foundation. [Ch. V; § 2 and Ch. VI, § 4, By-Laws of Maricopa Foundation, MF-122]

12. With respect to plaintiff's Statement 12, included in the powers of Maricopa Foundation's Board of Trustees is the power to recommend for approval to its membership maximum reimbursable levels of compensation to doctors providing medical services to patients insured under Maricopa Foundation-endorsed health insurance plans. [Ch. V, § 2, By-laws of Maricopa Foundation, MF-122]

13. With respect to plaintiff's Statement 13, participating and cooperating members of Maricopa Foundation have the right to vote on the adoption of maximum reimbursable levels of compensation to doctors providing medical services to patients insured under Maricopa Foundation-endorsed health insurance plans. [RFA 34]

14. With respect to plaintiff's Statement 14 each participating member in Maricopa Foundation executes an application for membership wherein he agrees "to be bound during the period of the membership applied for with respect to maximum fees charged patients covered by Foundation sponsored plans by any fee determination by the Foundation consistent with the schedule adopted by the membership and agree also to be bound with respect to patients covered by Foundation sponsored plans during the period of membership applied for by any agreements, contracts, or statements of policy entered into or adopted by the Foundation concerning the rendering of medical care and the cost thereof" and wherein he further specifically states "I understand and agree that participating membership in the Foundation shall not affect the method of computation or amount of fees billed by me with respect to any medical care for any patient." [RFA 14; Affidavit of Anthony D. Mitten sworn to November 17, 1978, para. 3 and exhibit A thereto]

15. With respect to plaintiff's Statement 15, although the By-Laws of Maricopa Foundation provide for the existence of a standing committee entitled the "fee schedule committee" said committee never was a standing committee and only met infrequently on an ad hoc basis and has not existed since July 1977. [Ch. X, § 2, By-Laws of Maricopa Foundation, MF-122]

16. Maricopa Foundation has no information sufficient to admit or deny plaintiff's Statement 16.

17. Maricopa Foundation has no information sufficient to admit or deny plaintiff's Statement 17.

18. Maricopa Foundation has no information sufficient to admit or deny plaintiff's Statement 18.

19. Maricopa Foundation has no information sufficient to admit or deny plaintiff's Statement 19.

20. Maricopa Foundation has no information sufficient to admit or deny plaintiff's Statement 20.

21. Maricopa Foundation has no information sufficient to admit or deny plaintiff's Statement 21.

22. Maricopa Foundation has no information sufficient to admit or deny plaintiff's Statement 22.

23. Maricopa Foundation has no information sufficient to admit or deny plaintiff's Statement 23.

24. Maricopa Foundation has no information sufficient to admit or deny plaintiff's Statement 24.

25. Maricopa Foundation has no information sufficient to admit or deny plaintiff's Statement 25.

26. Maricopa Foundation has no information sufficient to admit or deny plaintiff's Statement 26.

27. Maricopa Foundation has no information sufficient to admit or deny plaintiff's Statement 27.

28. Maricopa Foundation has no information sufficient to admit or deny plaintiff's Statement 28.

29. Maricopa Foundation has no information sufficient to admit or deny plaintiff's Statement 29.

30. Maricopa Foundation has no information sufficient to admit or deny plaintiff's Statement 30.

31. With respect to plaintiff's Statement 31, as of February 1977, Maricopa Foundation's membership, including all classes of members, consisted of approximately 1,052 persons. Maricopa Foundation does not have information as to how many of them are medical doctors who reside in Maricopa County, Arizona. [RFA 268]

32. Maricopa Foundation has no information sufficient to admit or deny plaintiff's Statement 32.

33. With respect to plaintiff's Statement 33, Maricopa Foundation enters membership agreements with its participating and cooperating members annually. [RFA 13] Maricopa Foundation has no information sufficient to admit or deny plaintiff's Statement 33 with respect to Pima Foundation.

34. With respect to plaintiff's Statement 34, Maricopa Foundation repeats its response to plaintiff's Statement 14. Maricopa Foundation has no information sufficient to admit or deny plaintiff's Statement 34 with respect to Pima Foundation.

35. With respect to plaintiff's Statement 35, Maricopa Foundation repeats its responses to plaintiff's Statements 4 and 31.

36. With respect to plaintiff's Statement 36, Maricopa Foundation repeats its response to plaintiff's Statement 3.

37. With respect to plaintiff's Statement 37, both Maricopa Foundation and plaintiff have prepared relative value schedules based in part upon the 1964 edition of the Relative Value Schedule adopted by the California Medical Association, the Relative Value Guide adopted by the American Society of Anesthesiologists and the Relative Value Schedule of the American College of Radiology. [RFA 19, 21, 23; Supplemental Response of the State of Arizona to Maricopa Foundation's First Set of Interrogatories 22 through 25] Maricopa Foundation uses the relative value schedules prepared by it, together with conversion factors adopted by its membership, solely to determine the

maximum reimbursable levels of compensation payable by a third party payor to doctors for services rendered to patients insured under Maricopa Foundation-endorsed health insurance plans. [RFA 29] Maricopa Foundation has not publicized and encouraged the use of relative value schedules and does not prepare or publish any schedule of fees to be charged by doctors. Maricopa Foundation does not affect in any way prices paid for goods and products sold by doctors to individuals insured under Maricopa Foundation-endorsed health insurance plans and has no price list or schedule for them. [Affidavit of Anthony D. Mitten sworn to December 11, 1978, paras. 2 and 8] Maricopa Foundation has sent to its members lists of conversion factors used by it to determine maximum reimbursable levels of compensation to doctors providing medical services to patients insured under Maricopa Foundation-endorsed health insurance plans and has sent said lists to non-member doctors requesting membership information and applications. [RFA 57-58] Plaintiff has sent to doctors relative value schedules and conversion factors to be used by it to determine maximum reimbursable levels of compensation to doctors providing medical services to patients for which plaintiff has assumed a payment obligation. Maricopa Foundation has no information sufficient to admit or deny plaintiff's Statement 37 with respect to Pima Foundation.

38. With respect to plaintiff's Statement 38, participating and cooperating members of the Maricopa Foundation have the right to vote on the adoption of maximum reimbursable levels of compensation to doctors providing services to patients insured under Maricopa Foundation-endorsed health insurance plans. These votes have been conducted by mail ballot. Maricopa Foundation has not polled its members as to relative value schedules and unit conversion factors they prefer or relative value schedules and unit conversion factors they consider appropriate to Maricopa Foundation. [RFA 34, 35, 36, 156, 164 & 235] Maricopa Foundation has

not proposed any schedule of fees to be charged by its members. Maricopa Foundation has no information sufficient to admit or deny plaintiff's Statement 38 with respect to Pima Foundation.

39. Maricopa Foundation has no information sufficient to admit or deny plaintiff's Statement 39.

40. With respect to plaintiff's Statement 40, Maricopa Foundation repeats its response to plaintiff's Statement 38 and further states that mail ballots with respect to the maximum reimbursable levels referred to in Maricopa Foundation's response to plaintiff's Statement 38 were taken on or about July 1974, October 1975 and October 1977 and did not result in adoption of any schedule of fees to be charged.

41. With respect to plaintiff's Statement 41, Maricopa Foundation's By-Laws uses the language "uniform average or median fee schedules for medical services by the Foundation" to refer to the maximum reimbursable levels of compensation to doctors providing services to patients insured under Maricopa Foundation-endorsed health insurance plans. [Ch. II, § 5, By-Laws of Maricopa Foundation, MF-122] Maricopa Foundation does not use the term "uniform fee schedule" to refer to any schedule of fees to be charged by doctors. Maricopa Foundation has no information sufficient to admit or deny plaintiff's Statement 41 with respect to Pima Foundation.

42. With respect to plaintiff's Statement 42, Maricopa Foundation has stated from time to time in correspondence that maximum reimbursable levels of compensation to doctors providing services to patients insured under Maricopa Foundation-endorsed health insurance plans should approximate the median of physician charges for services

rendered. But see Maricopa Foundation's response to plaintiff's Statement 71 with respect to the relation between actual maximum reimbursable levels of compensation to doctors and usual and customary fees charged by doctors.

43. With respect to plaintiff's Statement 43, Maricopa Foundation has entered into agreements with insurers and other third party payors pursuant to which those insurers and third party payors agree to write health insurance for certain groups which is not inconsistent with Maricopa Foundation's "Minimum Standards for Foundation-Endorsed Group Insurance Programs." [RFA 11] Maricopa Foundation's "Minimum Standards for Foundation-Endorsed Group Insurance Programs" includes a maximum reimbursable payment schedule with respect to payments by the insurer or third party payor to doctors for services provided to patients insured under Maricopa Foundation-endorsed group insurance plans. [RFA 10] Insurers and other third party payors agree to reimburse doctors for services rendered to patients insured under Maricopa Foundation-endorsed health insurance plans, less any agreed deductible payable by the insured, in accordance with their usual and customary fees charged for such services but not to exceed the maximum reimbursable level of compensation set forth in Maricopa Foundation's "Minimum Standards for Foundation-Endorsed Group Insurance Programs." [RFA 12] Maricopa Foundation has no information sufficient to admit or deny plaintiff's Statement 43 with respect to Pima Foundation.

44. With respect to plaintiff's Statement 44, Maricopa Foundation repeats its response to plaintiff's Statement 43.

45. With respect to plaintiff's Statement 45, Maricopa Foundation repeats its response to plaintiff's Statement 43.

46. With respect to plaintiff's Statement 46, Maricopa Foundations repeats its response to plaintiff's Statement 43.

47. With respect to plaintiff's Statement 47, Maricopa Foundation's "Minimum Standards for Foundation-Endorsed Group Insurance Programs" provides that "professional payments" by an insurer or other third party payor for services rendered to patients insured under Maricopa Foundation-endorsed health insurance plans are restricted to duly licensed physicians and surgeons of medicine and osteopathy, doctors of dentistry and doctors of podiatry. [MF-64] Maricopa Foundation has no information sufficient to admit or deny plaintiff's Statement 47 with respect to Pima Foundation.

48. With respect to plaintiff's Statement 48, Maricopa Foundation states that in each instance involving Maricopa Foundation the insurer or other third party payor retains the right to make the final determination of the maximum reimbursement to be made to any doctor for any service. Maricopa Foundation has no information sufficient to admit or deny plaintiff's Statement 48 with respect to Pima Foundation.

49. With respect to plaintiff's Statement 49, to determine the maximum reimbursable payment to a doctor for services rendered to a patient insured under a Maricopa Foundation-endorsed health insurance plan, one must refer both to the applicable relative value schedule and the applicable conversion factor. Maricopa Foundation's peer review must also determine that the services are medically necessary or appropriate before any payment is made. [RFA 17] Maricopa Foundation has no information sufficient to admit or deny plaintiff's Statement 49 with respect to Pima Foundation.

50. Maricopa Foundation denies plaintiff's Statement 50 and repeats its response to plaintiff's Statements 37 and 38. Maricopa Foundation has no information sufficient to admit or deny plaintiff's Statement 50 with respect to Pima Foundation.

51. With respect to plaintiff's Statement 51, plaintiff purports to have appended true and exact copies of consent decrees entered with respect to *In re California Medical Association*, FTC File No. 781005 (FTC, filed November 14, 1977) and *In re The American College of Radiology*, FTC File No. 7610059 (FTC, filed September 13, 1977) but they are irrelevant and immaterial to this action.

52. With respect to plaintiff's Statement 52, one possible definition for the term "relative value schedule" may be "a compilation of medical procedures to which are assigned unit values based upon the normal degree of complexity for each procedure; relative value schedules may also include a uniform nomenclature describing medical procedures and a standardized coding system for use by actuaries and others."

53. With respect to plaintiff's Statement 53, Maricopa Foundation repeats its response to plaintiff's Statement 37.

54. With respect to plaintiff's Statement 54, Maricopa Foundation repeats its response to plaintiff's Statement 37.

55. With respect to plaintiff's Statement 55, Maricopa Foundation repeats its response to plaintiff's Statement 37.

56. With respect to plaintiff's Statement 56, Maricopa Foundation denies that it published a conversion manual such as Exhibit H to plaintiff's Supplemental Rule 11(h) Statement with respect to plaintiff's Motion for Partial Summary Judgment.

57. Maricopa Foundation denies plaintiff's Statement 57 and repeats its responses to plaintiff's Statements 37, 38, 40 and 43.

58. Maricopa Foundation denies plaintiff's Statement 58, repeats its responses to plaintiff's Statements 37, 38, 40 and 43 and further states that Maricopa Foundation has on a non-periodic basis requested various professional organizations whose members are doctors to advise Maricopa Foundation in connection with Maricopa Foundation's in-

dependent determination of the maximum reimbursable levels of compensation to doctors providing medical services to patients insured under Maricopa Foundation-endorsed health insurance plans to be proposed to Maricopa Foundation's participating and cooperating members for adoption. Maricopa Foundation has not polled these various professional organizations as to relative value schedules and unit conversion factors their members use or the fees their members usually charge. [RFA 44-53] Maricopa Foundation has no information sufficient to admit or deny plaintiff's Statement 58 with respect to Pima Foundation.

59. Maricopa Foundation denies plaintiff's Statement 59.

60. With respect to plaintiff's Statement 60, Maricopa Foundation repeats its response to plaintiff's Statement 58.

61. With respect to plaintiff's Statement 61, Maricopa Foundation repeats its response to plaintiff's Statement 58.

62. Maricopa Foundation denies plaintiff's Statement 62.

63. With respect to plaintiff's Statement 63, Maricopa Foundation has on two occasions surveyed its members as to their usual and customary fees for medical services and as to what conversion factors and relative value schedules they used for the purpose of calculating their usual and customary fees for medical services. The results of those surveys were not published and were used solely to assist Maricopa Foundation in making an independent determination of the maximum reimbursable levels of compensation to doctors providing medical services to patients insured under Maricopa Foundation-endorsed health insurance plans to be proposed to Maricopa Foundation's participating and cooperating members. [RFA 37-43] Maricopa Foundation further responds by repeating its response to plaintiff's Statement 38.

64. With respect to plaintiff's Statement 64, Maricopa Foundation repeats its response to plaintiff's Statement 58.

65. With respect to plaintiff's Statement 65, Maricopa Foundation has sent to its members lists of conversion factors used by it to determine maximum reimbursable levels of compensation to doctors providing medical services to patients insured under Maricopa Foundation-endorsed health insurance plans and has sent said lists to non-member doctors requesting membership information and applications. Maricopa Foundation does not publish or distribute relative value schedules or conversion factors used by it to non-members except to insurers who may be interested in underwriting Maricopa Foundation-endorsed health insurance plans and persons eligible for membership in Maricopa Foundation who have expressed an interest in joining Maricopa Foundation. [RFA 57-58] Maricopa Foundation has no information sufficient to admit or deny plaintiff's Statement 65 with respect to Pima Foundation.

66. Maricopa Foundation has no information sufficient to admit or deny plaintiff's Statement 66.

67. With respect to plaintiff's Statement 67, Maricopa Foundation repeats its responses to plaintiff's Statement 37 and 65.

68. With respect to plaintiff's Statement 68, Maricopa Foundation repeats its response to plaintiff's Statement 65.

69. With respect to plaintiff's Statement 69, Maricopa Foundation repeats its responses to plaintiff's Statement 37 and 65.

70. With respect to plaintiff's Statement 70, Maricopa Foundation repeats its responses to plaintiff's Statements 14 and 34. Maricopa Foundation has no information sufficient to admit or deny plaintiff's Statement 70 with respect to Pima Foundation.

71. With respect to plaintiff's Statement 71, at no time has Maricopa Foundation set a maximum reimbursable level of compensation for medical services provided to patients insured under Maricopa Foundation-endorsed health insurance plans in excess of what Maricopa Foundation's

Board of Trustees believed to be the prevailing average or median usual and customary fee charged by doctors in Maricopa County for their services. [Affidavit of Anthony D. Mitten sworn to December 11, 1978, para. 6] Maricopa Foundation has no information sufficient to admit or deny plaintiff's Statement 71 with respect to Pima Foundation.

72. Maricopa Foundation denies plaintiff's Statement 72.

73. With respect to plaintiff's Statement 73, Maricopa Foundation has sent to Pima Foundation conversion factors used by Maricopa Foundation to determine maximum reimbursable levels of compensation to doctors providing medical services to patients insured under Maricopa Foundation-endorsed health insurance plans and states that it has no sufficient information to admit or deny the remainder of plaintiff's Statement 73 insofar as it pertains to Pima Foundation.

74. Maricopa Foundation has no information sufficient to admit or deny plaintiff's Statement 74.

75. With respect to plaintiff's Statement 75, it is the practice of Maricopa Foundation to advise insurers underwriting health insurance plans endorsed by Maricopa Foundation in advance of expected changes to maximum reimbursable levels of compensation to doctors providing medical services to patients insured under Maricopa Foundation-endorsed health insurance plans. [RFA 61] Maricopa Foundation has no information sufficient to admit or deny plaintiff's Statement 75 with respect to Pima Foundation.

76. With respect to plaintiff's Statement 76, Maricopa Foundation maximum reimbursement levels of compensation to doctors providing medical services to patients insured under Maricopa Foundation-endorsed health insurance plans effect payment to doctors and health insurance

premiums charged for Maricopa Foundation-endorsed health insurance plans. Maricopa Foundation has no information sufficient to admit or deny plaintiff's Statement 76 with respect to Pima Foundation.

77. With respect to plaintiff's Statement 77, on or about November 30, 1973, Maricopa Foundation asked an insurance consultant to provide actuarial assistance in estimating increases in premiums on Maricopa Foundation-endorsed health insurance plans likely to occur as a result of increases in the maximum reimbursable levels of compensation for doctors providing medical services to patients insured under Maricopa Foundation-endorsed health insurance plans proposed to become effective on or after January 1, 1974. [RFA 143]

78. With respect to plaintiff's Statement 78, on or about April 19, 1976, Maricopa Foundation's Board of Trustees approved an increase in Maricopa Foundation's deductible, which increase had been recommended by Maricopa Foundation's Insurance Advisory Committee, to provide greater flexibility in Maricopa Foundation's Minimum Standards in order for Maricopa Foundation-endorsed plans to continue to be saleable items. [Minutes of Maricopa Foundation Insurance Advisory Committee Meeting held March 18, 1976; Minutes of Maricopa Foundation Board of Trustees dated April 19, 1976]

79. With respect to plaintiff's Statement 79, plaintiff's Response to Maricopa Foundation's First Set of Interrogatories No. 9(A) reflects, *inter alia*, that in 1966, the State of Arizona paid approximately $75,867,000 to doctors in Arizona and Maricopa Foundation does not have sufficient information to admit or deny that statement.

80. With respect to plaintiff's Statement 80, plaintiff's Response to Maricopa Foundation's First Set of Interroga-

tories No. 9 reflect, *inter alia*, that in 1975, the State of Arizona paid approximately $218,279,000 to Arizona doctors and Maricopa Foundation does not have sufficient information to admit or deny that statement.

81. With respect to plaintiff's Statement 81, plaintiff's Response to Maricopa Foundation's First Set of Interrogatories No. 3(a) reflects, *inter alia*, that the State of Arizona, Division of Finance, pays approximately $7.6 million per year for health insurance premiums and Maricopa Foundation does not have sufficient information to admit or deny that statement.

82. With respect to plaintiff's Statement 82, plaintiff's Supplementary Response to Interrogatory 3(a) of defendant Maricopa Foundation for Medical Care's First Set of Interrogatories reflects, *inter alia*, the insurance premiums paid by the State of Arizona as set forth in plaintiff's Statement 82 and Maricopa Foundation does not have sufficient information to admit or deny that statement.

83. With respect to plaintiff's Statement 83, Maricopa Foundation administers the State of Arizona's Comprehensive Medical/Dental Program for Foster Children and makes payments to doctors providing services to foster children pursuant to the maximum allowable fee schedule of the Department of Economic Security, which schedule provides for payments in excess of those which would be made under Maricopa Foundation's maximum reimbursable levels of compensation to doctors providing services to patients insured under Maricopa Foundation-endorsed health insurance plans.

B. Maricopa Foundation incorporates herein by reference the facts set forth in the affidavits of Anthony D. Mitten, sworn to December 17, 1978 and December 11, 1978 which set forth material facts precluding summary judgment in favor of plaintiff.

July 31, 1979.

(Signature omitted in printing.)

Filed - AUG 22, 1979
Richard H. Deane, Clerk
U. S. Court of Appeals

(Caption omitted in printing.)

EMERGENCY MOTION OF APPELLEES MARICOPA FOUNDATION FOR MEDICAL CARE AND PIMA FOUNDATION FOR MEDICAL CARE TO VACATE INJUNCTION AND DISMISS APPEAL AND FOR EXPEDITED HEARING AND ACCELERATED BRIEFING

Appellees Maricopa Foundation for Medical Care ("Maricopa Foundation") and Pima Foundation for Medical Care ("Pima Foundation") move, pursuant to Rule 8(a) of the Federal Rules of Appellate Procedure and Rule 6(g) of the Rules of the United States Court of Appeals for the Ninth Circuit, for an order vacating the injunction entered by this Court August 17, 1979 herein and dismissing this appeal for lack of jurisdiction.

Alternatively, Maricopa Foundation moves, pursuant to Rule 8(b) of the Federal Rules of Appellate Procedure, for entry of an order conditioning continuation of the injunction entered by this Court August 17, 1979 herein upon the giving of security by appellant State of Arizona in the amount of not less than $850,000 and for an order setting this appeal for accelerated hearing on an emergency basis during September 1979 with acceleration of the briefing schedule for the appeal as is appropriate.

Additionally, Maricopa Foundation and Pima Foundation move, pursuant to Rule 27 of the Federal Rules of Appellate Procedure, for expedited hearing and accelerated briefing of this Motion and for its determination by Friday, August 31, 1979.

This motion is based upon the attached memorandum of points and authorities, the attached affidavits of Anthony D. Mitten sworn to August 22, 1979, Lawrence Shapiro sworn to August 22, 1979, and Philip P. Berelson sworn to August 22, 1979. Pima Foundation will supplement this motion with an affidavit of one of its officers. Some of the grounds advanced in support of this motion were not submitted to the District Court for the reason that the questions of whether this Court has erred in entering an injunction pending appeal and in taking jurisdiction of this matter where never before the District Court and it would not be appropriate for the District Court to consider those questions on remand.

Opposing counsel are Robert K. Corbin, Attorney General of the State of Arizona, Kenneth R. Reed, Chief Counsel, Antitrust Division, and Patricia A. Metzger, Assistant Attorney General, Antitrust Division, 303 West Wing, State Capitol Building, Phoenix, Arizona 85007, tel. 602/255-4751.

Moving counsel for Maricopa Foundation are Philip P. Berelson, Jennifer B. Beaver, Robert C. Houser, Brown & Bain, P.A., 222 North Central Avenue, Phoenix, Arizona 85004, tel. 602/257/8777, and for Pima Foundation, Robert O. Lesher, Lesher, Kimble & Rucker, P.C., 3773 East Broadway, Tucson, Arizona 85716, tel. 602/795-1470.

Counsel for the other appellee, who has authorized Maricopa Foundation's counsel to represent that its client is in favor of the granting of this motion, is Daniel J. McAuliffe, Snell & Wilmer, 3100 Valley Bank Center, Phoenix, Arizona 85073, tel. 602/257-7272, attorneys for appellee Maricopa County Medical Society.

August 22, 1979.

(Signatures omitted in printing.)

(Caption omitted in printing.)

AFFIDAVIT OF
LAWRENCE SHAPIRO

STATE OF ARIZONA }
} ss.
County of Maricopa }

LAWRENCE SHAPIRO, being first duly sworn, upon oath deposes and says:

1. I am Vice President of Maricopa Foundation for Medical Care ("Maricopa Foundation") and from January 1, 1976 to December 31, 1977 I was President of Maricopa Foundation. I have been a member of the Board of Trustees of Maricopa Foundation from 1971 through the present time. I make this affidavit in support of Maricopa Foundation's emergency motion to vacate the injunction entered by the Ninth Circuit Court of Appeals pending determination of the State of Arizona's ("Arizona") appeal from the Order of the District Court vacating temporary restraining order.

2. Based on my experience as a medical doctor practicing in Maricopa County and as a member of the Board of Trustees and officer of Maricopa Foundation, unless this Court vacates the injunction entered by it on August 17, 1979 in this matter, appellee Maricopa Foundation will cease to function as a viable competitive alternative for provision of health care services at the end of 1979. My belief is based upon the facts set forth below.

3. It is my belief that the marketability of Maricopa Foundation-endorsed health insurance depends in large part on (a) consumers' desire to purchase insurance such as Foundation-endorsed insurance which will pay 100% of physicians' charges for any given service; (b) consumers' desire to have a wide choice of physicians who have agreed to accept as payment in full the payment from the insurer; (c) competitive price of Foundation-endorsed insurance relative to other health insurance plans.

4. It is my belief that unless the Maricopa Foundation is able to increase the maximum amounts paid for various medical services, physicians who presently belong to Maricopa Foundation will find it economically impossible to continue their membership because the difference between maximum amounts paid by Maricopa Foundation and amounts charged by physicians in Maricopa County has grown steadily since the last Maricopa Foundation maximum reimbursement rate increase in December 1977.

5. Therefore, many Maricopa Foundation member physicians will not renew their membership for 1980 and as a result the advantage to the consumer of Maricopa Foundation-endorsed insurance coverage, *i.e.*, their desire to have a wide choice of physicians who accept Maricopa Foundation payment as payment in full, will disappear.

6. I believe that insurance groups which have in the past utilized Maricopa Foundation-endorsed insurance as one of the health care alternatives available to their employees are unlikely to renew offering Maricopa Foundation-endorsed health care insurance as an alternative in 1980 if Maricopa Foundation is not permitted to increase the maximum levels of reimbursement which it pays for medical services to patients insured under Maricopa Foundation endorsed health insurance. Patients who are treated by physicians who are not Maricopa Foundation members are obligated to pay the difference between Maricopa Foundation's maximum reimbursement rate and the billing they receive from their physician. At present, the difference between the Maricopa Foundation maximum reimbursement rate and the usual and customary fees charged by the majority of physicians in the community is so great that any prospect of a substantial decrease in the number of physicians who are members of the Maricopa Foundation obligated to accept its maximum reimbursement rates as payment in full

will make non-Maricopa Foundation-endorsed health insurance more attractive in terms of total cost to the insurer and to the patient than Maricopa Foundation-endorsed insurance.

7. For the reasons set forth above, I believe that if Maricopa Foundation is required not to change any relative value or conversion factor while Arizona's appeal is pending, that the practical effect will be the same as if a permanent injunction had been entered against Maricopa Foundation since Maricopa Foundation will not be a viable health insurance alternative by the time that the pending appeal is finally determined.

(Signature and notary clause omitted in printing)

(Caption omitted in printing.)

AFFIDAVIT OF ANTHONY D. MITTEN

STATE OF ARIZONA }
} ss.
County of Maricopa }

ANTHONY D. MITTEN, being duly sworn, upon oath deposes and says:

1. I am Executive Director of defendant-appellee Maricopa Foundation for Medical Care ("Maricopa Foundation"). I make this affidavit in support of Maricopa Foundation's emergency motion to vacate the injunction entered by the Ninth Circuit Court of Appeals pending determination of the State of Arizona's appeal from the order of the District Court vacating temporary restraining order.

2. Maricopa Foundation presently limits compensation to physicians who provide services to patients insured under Maricopa Foundation endorsed health insurance programs in accordance with a maximum level of reimbursement that has been in effect since December 1, 1977.

3. Increasing numbers of Maricopa Foundation member physicians have requested that they be allowed to terminate their memberships because Maricopa Foundation's current maximum levels of reimbursement in many cases do not adequately compensate the physicians for the services they provide. I believe that unless Maricopa Foundation is permitted to announce before the end of 1979 that it will increase maximum levels of reimbursement to Maricopa Foundation members for treating patients insured under Maricopa Foundation endorsed health insurance plans, that between one-quarter and one-half of the physician membership will refuse to renew their membership at the end of 1979. That loss of physician membership by Maricopa Foundation will result in Mari-

copa Foundation endorsed health insurance plans no longer being a viable alternative health care plan for the large employer groups which are currently using Maricopa Foundation endorsed health insurance plans.

4. Under contracts currently in force, Maricopa Foundation will be paid in excess of $700,000 in fees for administering health insurance plans during 1979. Based upon my experience as Executive Director of Maricopa Foundation I believe that if the injunction entered by the Ninth Circuit Court of Appeals remains in force, Maricopa Foundation's income from administering insurance plans will be reduced by between $400,000 and $450,000 in 1980. If that injunction remains in force and Arizona's appeal is not decided during 1980, in my opinion Maricopa Foundation's income from administering health insurance plans will be reduced by in excess of $450,000 in 1981.

5. Under Maricopa Foundation's regular procedure it is unable to make any modification to relative values or conversion factors or maximum reimbursement levels in less than sixty days. In addition, Maricopa Foundation has normally given insurers no less than sixty days advance notice of any significant change in maximum reimbursement levels in order for the insurer to evaluate the impact of the change and determine whether or not to continue to offer a Maricopa Foundation endorsed health insurance plan. For that reason, if the injunction entered by the Ninth Circuit Court of Appeals is not vacated by the beginning of September 1979, Maricopa Foundation will be damaged and, as the month of September goes by, the damage will become increasingly more severe. Motorola, Incorporated ("Motorola") insures the largest Maricopa Foundation endorsed health insurance group. Maricopa Foundation must inform Motorola of any anticipated change in maximum reimbursement levels for Maricopa Foundation endorsed health insurance in September or its contractual relationship with Motorola will be irreparably damaged. It is extremely unlikely that Motorola will continue any contrac-

tual relationship with Maricopa Foundation if Maricopa Foundation is unable to discuss with Motorola changes to relative values and conversion factors which will be used in connection with Motorola's insureds during 1980.

6. For the foregoing reasons I respectfully but earnestly request that Maricopa Foundation's motion be granted as soon as possible in order to minimize the harm which Maricopa Foundation will inevitably suffer as a result of the injuction order which was filed August 17, 1979.

(Signature and notary clause omitted in printing.)

(Caption omitted in printing.)

AFFIDAVIT OF THOMAS P. FINLEY

STATE OF ARIZONA }
} ss.
County of Maricopa }

THOMAS P. FINLEY, being first duly sworn upon oath, deposes and says:

1. I am Executive Director fo Defendant-Appellee Pima Foundation for Medical Care (PFMC). I make this affidavit in support of Pima Foundation's emergency motion to vacate the injunction entered by the Ninth Circuit Court of Appeals pending determination of the State of Arizona's appeal from the Order of the District Court vacating Temporary Restraining Order.

2. Pima Foundation presently limits compensation to physicians who provide services to patients insured under Pima Foundation-endorsed health insurance programs in accordance with a maximum level of reimbursement that has been in effect since December 1, 1977.

3. Increasing numbers of Pima Foundation member physicians have requested that they be allowed to terminate their memberships because Pima Foundation's current maximum levels of reimbursement in many cases do not adequately compensate the physicians for the services they provide. I believe that unless Pima Foundation is permitted to announce before the end of 1979 that it will increase maximum levels of reimbursement to Pima Foundation members for treating patients insured under Pima Foundation endorsed health insurance plans that between one-quarter andd one-third of the physician membership will refuse to renew their membership at the end of 1979. That loss of physician membership by Pima Foundation will re-

sult in Pima Foundation-endorsed health insurance plans no longer being a viable alternative health care plan for the large employer groups which are currently using Pima Foundation endorsed health insurance plans.

4. Under contracts currently in force, Pima Foundation will be paid in excess of $77,000 in fees for administering health insurance plans during 1979. Based upon my experience as Executive Director of Pima Foundation, I believe that if the injunction entered by the Ninth Circuit Court of Appeals remains in force, Pima Foundation's income from administering insurance plans will be reduced by between $25,000 and $40,000 in 1980. If that injunction remains in force and Arizona's appeal is not decided during 1980, in my opinion, Pima Foundation's income from administering health insurance plans will be reduced by in excess of $45,000 in 1981.

5. Under Pima Foundation's regular procedure, it is unable to make any modification to relative values or conversion factors or maximum reimbursement levels in less than 60 days. In addition, Pima Foundation has normally given insurers no less than 60 days advance notice of any significant change in maximum reimbursement levels in order for the insurer to evaluate the impact of the change and determine whether or not to continue to offer a Pima Foundation-endorsed health insurance plan. For that reason, if the injunction entered by the Ninth Circuit Court of Appeals is not vacated by the beginning of September, 1979, Pima Foundation will be damaged, and, as the month of September goes by, the damage will become increasingly more severe. Tucson Public School District No. 1 insures the largest Pima Foundation-endorsed health insurance group. Pima Foundation must inform Tucson Public School District No. 1 of any anticipated change in maximum reimbursement levels for Pima Foundation-endorsed health insurance in September, or its contractual relationship with Tucson Public School District will be irreparably damaged. It is extremely unlikely that Tucson Public School District

will continue any contractual relationship with Pima Foundation if Pima Foundation is unable to discuss with Tucson Public School District changes to relative values and conversion factors which will be used in conjunction with Tucson Public School District's insureds during 1980. This same situation applies to the Sunnyside School District, which is Pima Foundation's next largest account.

6. For the foregoing reasons, I respectfully and urgently request that Pima Foundation's Motion be granted as soon as possible to order to minimize the harm which Pima Foundation will inevitably suffer as a result of the injunction order which was filed August 17, 1979.

(Signature and notary clause omitted in printing.)

(Caption omitted in printing.)

AFFIDAVIT OF ARTHUR DUDLEY, JR., M.D.

STATE OF ARIZONA }
} ss.
County of Pima }

ARTHUR DUDLEY, being first duly sworn, upon oath deposes and says:

1. I am President of the Pima Foundation for Medical Care. As President, I serve as the governing member of the Board of Trustees of the Pima Foundation. I make this affidavit in support of Pima Foundation's emergency motion to vacate the injunction entered by the Ninth Circuit Court of Appeals pending determination of the State of Arizona's ("Arizona") appeal from the Order of the District Court vacating temporary restraining order.

2. Based on my experience as a medical doctor practicing in Pima County and as a member of the Board of Trustees and officer of Pima Foundation, unless this Court vacates the injunction entered by it on August 17, 1979, in this matter, appellee Pima Foundation will cease to function as a viable competitive alternative for provision of health care services at the end of 1979. My belief is based upon the facts set forth below.

3. It is my belief that the marketability of Pima Foundation endorsed health insurance depends in large part on (a) consumers' desire to purchase insurance such as Foundation-endorsed insurance which will pay 100% of physicians' charges for any given service; (b) consumers' desire to have a wide choice of physicians who have agreed to accept as payment in full the payment from the insurer; and (c) competitive price of Foundation-endorsed insurance relative to other health insurance plans.

4. It is my belief that unless the Pima Foundation is able to increase the maximum amounts paid for various medical services, physicians who presently belong to Pima Foundation will find it economically impossible to continue their

membership because the difference between maximum amounts paid by Pima Foundation and amounts charged by physicians in Pima County has grown steadily since the last Pima Foundation maximum reimbursement rate increase in December, 1977.

5. Therefore, many Pima Foundation member physicians will not renew their membership for 1980, and as a result, the advantage to the consumer of Pima Foundation-endorsed insurance coverage, i.e., their desire to have a wide choice of physicians who accept Pima Foundation payment as payment in full will disappear. In support of this statement, twenty anesthesiologists have already submitted their resignation to the Pima Foundation for Medical Care. In addition, forty-one members have submitted notice of resignation, primarily in the fields of obstetrics and gynecology and radiology. The principal underwriter of Pima Foundation contracts, Connecticut General Life Insurance Company is presently reimbursing for anesthesia services utilizing a conversion factor of $19 for their indemnity contracts. The Pima Foundation rate of reimbursement for the same service is based upon a conversion factor of $13.

6. The resignations of the anesthesiologists will be particularly detrimental to the Pima Foundation's efforts to market its product.

7. I believe that insurance groups which have in the past utilized Pima Foundation-endorsed insurance as one of the health care alternatives available to their employees are unlikely to renew offering Pima Foundation-endorsed health care insurance as an alternative in 1980 if Pima Foundation is not permitted to increase the maximum levels of reimbursement which it pays for medical services to patients insured under Pima Foundation-endorsed health insurance. Patients who are treated by physicians who are not Pima Foundation members are obligated to pay the difference between Pima Foundation's maximum reimbursement rate and the billing they receive from their physician.

At present, the difference between the Pima Foundation maximum reimbursement rate and the usual and customary fees charged by the majority of physicians in the community is so great that any prospect of a substantial decrease in the number of physicians who are members of the Pima Foundation obligated to accept its maximum reimbursement rates as payment in full will make non-Pima Foundation-endorsed health insurance more attractive in terms of total cost to the insurer and to the patient than Pima Foundation-endorsed insurance.

For the reasons set forth above, I believe that if Pima Foundation is required not to change any relative value or conversion factor while Arizona's appeal is pending that the practical effect will be the same as if a permanent injunction had been entered against Pima Foundation since Pima Foundation will not be a viable health insurance alternative by the time the pending appeal is finally determined.

(Signature and notary clause omitted in printing.)

Filed - MAY 30 1980
W. J. Furstenau, Clerk
U. S. District Court
For The District of Arizona

(Caption omitted in printing.)

ORDER

Before: SNEED and KENNEDY, Circuit Judges, and LARSON,*[1] District Judge

Plaintiff-Appellant's Petition for Rehearing and Suggestion of Appropriateness of Rehearing In Banc is ordered filed.

Filed - JUN 18 1980
W. J. Furstenau, Clerk
U. S. District Court
For The District of Arizona

(Caption omitted in printing.)

ORDER

Before: SNEED and KENNEDY, Circuit Judges, and LARSON,*[2] District Judge

The panel as constituted in the above case has voted to deny the petition for rehearing and to reject the suggestion for rehearing en banc.

The full court has been advised of the suggestion for en banc rehearing, and no judge of the court has requested a vote on the suggestion for rehearing en banc. Fed. R. App. P. 35(b).

The petition for rehearing is denied and the suggestion for a rehearing en banc is rejected.

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*[1]Honorable Earl R. Larson, Senior United States District Judge for the District of Minnesota, sitting by designation.

*[2]Honorable Earl R. Larson, Senior United States District Judge for the District of Minnesota, sitting by designation.

Supreme Court, U. S.
FILED
OCT 20 1980
MICHAEL RODAK, JR., CLERK

No. 80-419

In the Supreme Court
OF THE
United States

OCTOBER TERM, 1980

STATE OF ARIZONA,

Petitioner,

vs.

MARICOPA COUNTY MEDICAL SOCIETY, MARICOPA FOUNDATION FOR MEDICAL CARE, AND PIMA FOUNDATION FOR MEDICAL CARE,

Respondents.

JOINT BRIEF IN OPPOSITION TO THE STATE OF ARIZONA'S PETITION FOR A WRIT OF CERTIORARI

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RESTATEMENT OF QUESTION PRESENTED

On Petitioner's motion for partial summary judgment the undisputed facts established an agreement among the physicians who are members of a medical foundation that (1) each would charge his individual customary fee, but (2) with respect to patients covered by health insurance endorsed by that medical foundation each would accept as payment in full the amount paid by that insurance and not to try to recover from the patient any difference between the insurance payment and the fee billed if the fee was higher than the foundation's maximum level of reimbursement. Accordingly, it is submitted that the question presented must be restated as follows:

Did the Court of Appeals err in deciding the agreement among foundation member physicians was not properly characterized by Petitioner as horizontal "price-fixing" that is a *per se* violation of Section 1 of the Sherman Act and the action should proceed to trial to determine the economic effects of that agreement?

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No. 80-419

In the Supreme Court
OF THE
United States

OCTOBER TERM, 1980

STATE OF ARIZONA,

Petitioner,

vs.

MARICOPA COUNTY MEDICAL SOCIETY, MARICOPA FOUNDATION FOR MEDICAL CARE, AND PIMA FOUNDATION FOR MEDICAL CARE,

Respondents.

JOINT BRIEF IN OPPOSITION TO THE STATE OF ARIZONA'S PETITION FOR A WRIT OF CERTIORARI

The Maricopa Foundation for Medical Care, the Pima Foundation for Medical Care and the Maricopa County Medical Society respectfully pray that this Court refuse to issue a writ of certiorari to review the decision of the United States Court of Appeals for the Ninth Circuit entered on March 20, 1980, as modified on April 28, 1980.

COUNTERSTATEMENT OF THE CASE

Petitioner's "Statement of the Case" distorts the record almost beyond recognition. This action does *not* involve an agreement by doctors on prices to charge their patients or circulation to doctors of schedules of fees to

be charged. Petitioner has attempted on a motion for partial summary judgment to affix conclusory, simplistic and misleading labels to a complex situation in an effort to condemn Respondents' conduct by characterizing it as a *per se* illegal horizontal price-fixing combination.

There is substantial dispute among the parties as to the "facts" upon which Petitioner has based its "Statement of the Case." It cites almost exclusively to Petitioner's "Statement of Undisputed Facts," CR 106. Despite the title of Petitioner's submission, each of the "undisputed facts" cited in the petition to this Court was disputed by one or more of the Respondents.[1] This action has not advanced beyond motions for summary judgment, discovery has not been completed and there has been no trial on the merits. Therefore the factual record is incomplete.

The Facts About the Respondents and the Conduct Petitioner Challenges

Contrary to Petitioner's assertion, it has failed to prove that there is a "fee schedule" as to what physicians bill or charge patients in this action.[2] The majority of the Ninth Circuit panel correctly perceived that "[t]he challenged conduct is the setting by majority vote of maximum fees that physician members may claim in full payment for health services they provide to policyholders of FMC-approved insurance plans."[3] The District Court found " the doctors who agree to participate in the

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[1]See CR 54 and 122.

[2]CR 122, paras. 37, 41.

[3]Pet. App. A at 2, CR 99 at 2.

foundation-approved plans are free to set the prices they charge their patients."[4]

Physician members of a foundation specifically agree that "participating membership in the foundation shall not affect the method of computation or amount of fees billed by me with respect to any medical care for any patient."[5] Foundation member physicians agree to accept as payment in full for patients covered by foundation endorsed insurance the *maximum* level of reimbursement from the insurer for services rendered if they bill *more* than that level (and are paid *less* than that level if they bill less).[6] What the member physician is paid by the foundation endorsed insurance may not fully compensate him for the services provided but he cannot collect any more from the covered patient. A foundation's use of defined dollar limits rather than a variable level based on usual and customary fees to determine maximum insurance reimbursement levels, which is attacked by Petitioner, is essential to the concept and operation of foundation insurance plans. The marketability of foundation endorsed health insurance depends in large part on consumers' desire to purchase a health plan such as foundation endorsed insurance which will pay 100% of physicians' charges for any given service.[7]

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[4]Pet. App. D at 39.

[5]CR 25, Exhibit A at para. 4, Affidavit of Anthony D. Mitten, sworn to November 17, 1978 ("Mitten Affidavit").

[6]CR 25, Mitten Affidavit, para. 4.

[7]Emergency Motion of Appellees Maricopa Foundation for Medical Care and Pima Foundation for Medical Care to Vacate Injunction and Dismiss Appeal and for Expedited Hearing and Accelerated Briefing, dated August 22, 1979, Affidavit of Lawrence Shapiro, sworn to August 22, 1979, para. 3.

A foundation only revises its maximum reimbursement levels when its Board of Trustees feels they have fallen so far below usual and customary fees that physicians will resign from or refuse to renew membership in the foundation if they are not revised. Revisions do not occur at any regular interval.[8] In the case of Maricopa Foundation, its Board of Trustees has never set a maximum reimbursement level in excess of what the Board believed to be prevailing average or median fees charged by physicians in the community.[9]

The agreements which a foundation enters into with insurers only concern the foundation endorsed insurance they underwrite. They provide that with respect to such plans the insurers agree to cover at least those medical services described in the foundation's minimum standards and to reimburse physicians for services rendered to patients insured under foundation endorsed health insurance plans in accordance with each physician's usual and customary fees charged for such services but not to exceed the maximum level of reimbursement established by the foundation.[10] A foundation reviews the medical necessity and appropriateness of treatment and, for some insured groups, also reviews utilization of hospital services. Following the medical review, it makes payment on claims for certain insured groups. In each instance, the foundation acts as an agent of an insurer who underwrites the health insurance plan.[11] Maricopa Foundation estimates it has saved patients and their in-

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[8]CR 57, para. 3.

[9]CR 57, para. 6.

[10]CR 54, paras. 21, 22.

[11]CR 25, Mitten Affidavit, paras. 2, 3.

surers over $6 million in medical fees.[12] Petitioner does not dispute that those reductions in medical costs have occurred.

Patients insured by foundation endorsed insurance plans need not go to foundation members for treatment. They are free to enlist the services of any physician of their choice.[13] In addition to free choice of physicians, the benefits to insured patients are the possibility of lower insurance premiums (due to the savings on fees paid), assurance that if a foundation member physician is used the insured will not have to pay any difference between what the physician bills and what the insurance will reimburse[14] and knowledge that the physician will be restrained from performing unnecessary treatment because a qualified physician will review the treatment performed to determine if it is medically necessary or appropriate.[15] Thus the foundations offer a health care service different from that which individual physicians or individual insurers could separately provide to the public.

Petitioner failed to adduce any evidence to support its price-fixing claims and erroneously relies solely upon the existence of Maricopa and Pima Foundations and their use of conversion factors and relative value schedules to establish maximum reimbursement levels for health insurance. A foundation uses relative value schedules and conversion factors to determine the maximum reimbursable levels of compensation for medical services

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[12]CR 106, Ex. E, preamble, at 3.

[13]CR 25, Mitten Affidavit, para. 4.

[14]CR 54, para. 2.

[15]CR 25, Mitten Affidavit, para. 2.

provided to patients insured under foundation endorsed health insurance plans.[16] All physicians are free to bill as they like and are treated the same whether or not they belong to a foundation. Any physician treating a patient covered by foundation endorsed insurance will be paid under the insurance in the same manner (*i.e.*, up to the foundation's maximum level of reimbursement). While foundation member physicians agree to accept that reimbursement by the insurer as payment in full and do not look to the patient to pay the difference between the physician's bill and the amount paid by the insurer, nonmember physicians are free to obtain from the patient the difference between the maximum reimbursement rate paid by the insurer and the amount of the bill directly from the patient.[17]

Arizona itself prepares and circulates both relative value schedules and conversion factors which are used to determine payments by Arizona to physicians for their services in, *inter alia*, workmen's compensation cases.[18] In many instances, Arizona's maximum reimbursement levels have been higher than those of the foundations.[19] Unlike the Arizona Industrial Commission, a foundation does not distribute relative value schedules to physicians. It only informs its members of the conversion factors it uses to calculate maximum reimbursement

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[16]CR 57, para. 2.

[17]*Id.*

[18]Brief of Defendant-Appellee Maricopa Foundation for Medical Care, dated September 12, 1979, Exhibit A (Supplemental Response of the State of Arizona to Defendant Maricopa Foundation for Medical Care's First Set of Interrogatories, Nos. 22 through 25, dated July 13, 1979).

[19]CR 62, para. 8.

levels for medical services to patients insured under foundation endorsed health insurance plans.[20]

Maricopa Foundation has a contract with Arizona to administer the Comprehensive Medical Dental Program for Foster Children. It makes payments to physicians under that program pursuant to the maximum allowable fee schedule of Arizona's Department of Economic Security, which provides for higher payments than those which would be made under Maricopa Foundation's own maximum levels of reimbursement to doctors providing services to patients insured under Maricopa Foundation endorsed health insurance plans.[21]

The evidence in the record does not establish that the foundations have exercised any control whatsoever over the prices physicians charge or dampened price competition among them. For example, the record shows Maricopa Foundation has not requested, urged or even suggested that a physician increase any fee or taken any action with respect to any doctor as a result of any fee billed, except to bring to the attention of the Arizona Board of Medical Examiners pursuant to Ariz. Rev. Stat. § 32-1451 (1976) those instances in which, in the opinion of its Board of Trustees, the fee charged was so excessive as to constitute unprofessional conduct.[22] Petitioner has presented no factual support for its assertion that the foundations' maximum levels of insurance reimburse-

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[20]CR 122, para. 37.

[21]CR 122, para. 83.

[22]CR 57, paras. 6, 9. Furthermore, Respondent Maricopa Foundation does not and never has taken any position with respect to the amount of fees a physician should bill any patient. CR 25, Mitten Affidavit, paras. 3, 4.

ment either are intended to be schedules of fees physicians should bill their patients or have operated as such. In fact, the maximum levels of reimbursement adopted by the Maricopa and Pima Foundations in 1977 are substantially different.[23] There is no evidence of any relationship between the fees physicians in Maricopa and Pima Counties charge their patients and the foundations' maximum reimbursement levels.[24]

Petitioner does not dispute that the Respondent foundations were established to provide residents of Pima and Maricopa Counties with a competitive alternative to utilization of closed panel prepaid health insurance plans.[25] The foundations' medical insurance programs provide a unique competitive alternative that directly promotes competition, with demonstrable benefits to insured patients. Petitioner has utterly failed to produce any evidence of uniformity of pricing or that physicians' prices changed as a result of any change in foundation maximum reimbursement levels.

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[23]Compare Exhibit B (Response of Maricopa Foundation for Medical Care to Plaintiff's First Request for Admissions and Interrogatories), para. 304 with Exhibit C (Response of Pima Foundation for Medical Care to Plaintiff's First Request for Admissions and Interrogatories), para. 413 in Brief of Defendant-Appellee Maricopa Foundation for Medical Care, dated September 12, 1979.

[24]While the foundations had not changed their maximum reimbursement levels since 1977, medical fees have, not surprisingly, increased. [CR 103, Mitten Affidavit, para. 3.] Therefore, it should be of no surprise to this Court that in 1979 eighty-five to ninety-five percent of physicians in Maricopa County billed at or above the maximum reimbursement levels adopted by Maricopa Foundation in 1977.

[25]The effect, if any, of the foundations on closed panel prepaid health insurance plans, commonly called Health Maintenance Organizations or HMOs, is not an issue in the proceedings for which Petitioner seeks review.

The District Court's Decision

The District Court's denial of Petitioner's motion for partial summary judgment that Respondents' conduct constituted a *per se* violation of section 1 of the Sherman Act, 15 U.S.C. § 1 (1977), followed a two-pronged analysis.[26] First, the District Court refused to apply blindly and mechanically the *per se* analysis demanded by Petitioner, recognizing that not all joint conduct constitutes *per se* violations. The court relied on *Continental T. V., Inc. v. GTE Sylvania, Inc.*, 433 U.S. 36 (1977) and *General Glass Co. v. Globe Glass & Trim Co.* [1978-2] Trade Cas. (CCH) ¶ 62,231 (N.D. Ill. 1978).[27] The second prong of the opinion recognized that, since the case concerns the medical profession, the court should give Respondents the opportunity to show that the challenged conduct promoted improvement of professional services to the public. It based that decision upon *Goldfarb v. Virginia State Bar*, 421 U.S. 773, 788 n. 17 (1975), *National Society of Professional Engineers v. United States*, 435 U.S. 679, 686 (1978), *Boddicker v. Arizona State Dental Association*, 549 F.2d 626, 632 (9th Cir.), *cert. denied*, 434 U.S. 825 (1977), and *Mackey v. National Football League*, 543 F.2d 606 (8th Cir. 1976). The District Court found Respondents' activities to be more properly tested by the

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[26]While the District Court denied defendants' motions to dismiss on the basis of the McCarran-Ferguson Act, 15 U.S.C. § 1012 (1977), that interlocutory determination has not been appealed as of yet.

[27]The District Court did not rule that *Continental T. V.* "established" a trend away from a *per se* approach, as claimed by Petitioner at p. 6. Furthermore, just prior to the District Court's decision, this Court decided Broadcast Music, Inc. v. Columbia Broadcasting System, Inc., 441 U.S. 1 (1979) which, as will be shown *infra*, supports the District Court's reasoning.

Rule of Reason standard than the rigid *per se* liability analysis which would follow from accepting Petitioner's characterization.[28] It ordered that Petitioner's motion for summary judgment be denied, but specifically allowed Petitioner to file a similar motion based on additional evidence. Petitioner accepted the District Court's invitation to elaborate upon the factual basis of its partial summary judgment motion by filing Plaintiff's Motion for Summary Judgment and Permanent Injunction, CR 105. That summary judgment motion purported to present facts adequate to establish Respondents' Sherman Act liability under a Rule of Reason standard. Applying the Rule of Reason standard in accordance with Petitioner's invitation, the District Court denied Petitioner's motion for summary judgment and permanent injunction, Minute Entry filed August 6, 1979. Subsequently, Petitioner brought an interlocutory appeal from the District Court's denial of Petitioner's first motion for partial summary judgment.

The Court of Appeals' Decision

The Ninth Circuit's decision affirmed the District Court's denial of summary judgement. It held that given the facts in the record on appeal, it could not rule that the District Court erred in denying either (a) Petitioner's requested preliminary injunction or (b) Petitioner's motion for partial summary judgement.

Judges Sneed and Kennedy looked to *Broadcast Music Inc. v. Columbia Broadcasting System, Inc.*, 441 U.S. 1 (1979) for guidance. Citing *Broadcast Music*, Judge Sneed noted "that whether to classify something as *'per*

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[28]The District Court did *not* intimate that *per se* analysis never applied to learned professions.

se price fixing' will often, but not *always*,be a simple matter."[29] He described the factual uncertainties in this action which include, *inter alia:*

> 1. The record reveals nothing about the actual effects of Respondents' activities on competition [Pet. App. A at 5];
>
> 2. Petitioner's own maximum reimbursement levels for its workmen's compensation insurance program and foster children care program are higher than those of the foundations [*id.* at 3];
>
> 3. The record does not establish that profits (from what Judge Sneed assumed to be a monopoly of medical care by doctors) have been increased by the challenged conduct[30] [*id.* at 6-7];
>
> 4. No evidence had been adduced that the insurance carriers which use the foundations would supinely accept the alleged price-fixing which Petitioner assumes has raised the costs the insurance carriers pay [*id.* at 7]; and
>
> 5. Nothing about the competitive interactions between the relevant economic actors, including Blue Cross and other health insurers, hospitals, and HMOs is revealed by the record [*id.* at 8-9].

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[29]Pet App. A at 8 (emphasis in original).

[30]The Court of Appeals stated that a rigid application of the *per se* rule would force it to accept the assumption that

> "the FMCs are but devices to enable the member doctors to capture a greater share of potential monopoly profit, which their monopoly power makes available, than otherwise would be possible. This is an assumption we are not prepared to make on the basis of the record before us." [Pet. App. A at 6-7.]

Judge Sneed concluded " [t]o affix the per se label to appellees' conduct is, however, once more to substitute an unsupported belief for proper proof."[31]

Contrary to Petitioner's assertion, Judges Sneed and Kennedy agree that the further evidence which would be adduced at trial might convince the trial court to classify the Respondents' challenged conduct as "price-fixing" which in future cases might be subject to a *per se* standard of liability. They simply found a *per se* analysis inappropriate at the summary judgment stage of these proceedings, noting that the professions had only recently been brought within section 1 of the Sherman Act[32] and that guidelines for professional conduct are still being written.

Judge Kennedy stated " [p]er se rules should be derived from considerations of economic impact in particular cases illustrating the category of prohibited acts and therefore a trial is appropriate to explore further the impact on competition of the challenged reimbursement schedules."[33]

REASONS FOR DENYING THE WRIT

I. *Petitioner's Claim that The Ninth Circuit Has Adopted a "Reasonableness of the Agreed-upon Price" Defense Is Erroneous.*

The Circuit Court's primary reason for affirming denial of summary judgment was the lack of evidence of any anti-competitive effects from the challenged conduct.

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[31]Pet. App. A at 8.

[32]Citing *Goldfarb*, 421 U.S. at 758-88 [Pet. App. A at 5-6].

[33]Pet. App. A at 13.

It did not rely on a reasonableness of price defense.[34] It stated:

> "The State of Arizona insists that [Respondents'] practice . . . constitutes an arrangement without any redeeming virtue that suppresses and destroys competition and is thus unreasonable per se. The difficulty with Arizona's position is that this record reveals nothing about the actual competitive effects of the challenged arrangement nor do the authorities, primary or secondary, afford assurance concerning its competitive impacts. In truth, we know very little about the impact of this and many other arrangements within the health care industry. This alone should make us reluctant to invoke a per se rule with respect to the challenged arrangement."[35]

A careful reading in their entirety of the majority opinions affirming the denial of summary judgment inevitably leads to the conclusion that at this stage in the proceedings insufficient evidence has been introduced by Petitioner to convince either the District Court or the Circuit Court that the conduct at issue should simply be called "price-fixing." The Ninth Circuit adopted no "rea-

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[34]Petitioner's citation of McLain v. Real Estate Bd. of New Orleans, Inc., 444 U.S. 232 (1980) and United States v. United States Gypsum Co., 438 U.S. 422 (1978) is irrelevant. Contrary to Petitioner's assertion, the Ninth Circuit did not ignore the rule that, "in a civil action under the Sherman Act, liability may be established by proof of either an unlawful purpose or an anticompetitive effect." Petition at 10. The Ninth Circuit properly found the undisputed facts which had been offered in support of Petitioner's summary judgment motion to be insufficient to summarily determine in Petitioner's favor that Respondents were subject to either "unlawful purpose" or "anticompetitive effect" liability.

[35]Pet. App. A at 5.

sonableness of price defense" nor did it eliminate the possibility that after a full trial a *per se* analysis might be applied to similar conduct in the future if it were found anticompetitive and unlawful.

The Ninth Circuit's refusal to affix the horizontal price-fixing label to the Respondents' conduct on a motion for summary judgment conformed to the analysis mandated by *Broadcast Music*, where this Court held that the Rule of Reason should govern the determination of the legality of the blanket licensing practice at issue (which had been held to be *per se* illegal price-fixing by the Court of Appeals).

> "To the Court of Appeals and CBS, the blanket license involves 'price fixing' in the literal sense: the composers and publishing houses have joined together into an organization that sets its price for the blanket license itself. But this is not a question simply of determining whether two or more potential competitors have literally 'fixed' a 'price.' As generally used in the antitrust field, 'price fixing' is a shorthand way of describing certain categories of business behavior to which the *per se* rule has been held applicable. The Court of Appeals' literal approach does not alone establish that this particular practice is one of those types or that it is 'plainly anticompetitive' and very likely without 'redeeming virtue.' Literalness is overly simplistic and often overbroad . . . .
>
> Consequently, [citation omitted] '[i]t is only after considerable experience with certain business relationships that courts classify them as *per se* violations . . . .' "[36]

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[36]441 U.S. at 8-9.

This Court observed that while the *per se* rule "is a valid and useful tool of antitrust policy and enforcement," courts must not be too quick to seize upon it as a replacement for reasoned analysis of challenged practices: "[E]asy labels do not always supply ready answers."[37] This Court concluded that "[n]ot all arrangements among actual or potential competitors that have an impact on price are *per se* violations of the Sherman Act or even unreasonable restraints."[38]

The foundation endorsed insurance plans are, it is respectfully submitted, subject to the same type of analysis as the blanket licenses in the *Broadcast Music* case. As in that case, Petitioner has failed in this action to establish any agreement by competitors as to prices they will sell at on an individual basis. A foundation endorsed insurance plan is a health care service different from that which any individual physician or individual insurer could separately provide the public. In the complex health care industry, one in which the courts have not amassed considerable experience, the Ninth Circuit correctly refused to pin the "easy label" on the Respondents' conduct when Petitioner moved for summary judgment.

Broadcast Music is the most recent in a line of cases including *Continental T. V.*, in which this Court condemned the precipitous application of *per se* rules to all antitrust cases. This Court noted in overruling *United States v. Arnold, Schwinn & Co.*, 388 U.S. 365 (1967), that it "was an abrupt and largely unexplained departure from *White Motor Co. v. United States*, 372 U.S. 253, 83 S. Ct. 696, 9 L.Ed.2d 738 (1963), where only four years

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[37] *Id.* at 8.

[38] *Id.* at 23.

earlier this Court had refused to endorse a *per se* rule for vertical restrictions."[39]

In rejecting the truncated *per se* analysis employed in *Schwinn*, this Court plainly insisted that courts focus on the substantive orientation of the antitrust laws in analyzing particular cases, declaring: "'Realities must dominate the judgment. . . . The Anti-Trust Act aims at substance.'"[40] This Court emphasized that "[*p*]*er se* rules of illegality are appropriate only when they relate to conduct that is manifestly anti-competitive,"[41] and warned: "[W]e . . . make clear that departure from the rule of reason standard must be based upon demonstrable economic effect rather than—as in *Schwinn*—upon formalistic line drawing."[42] Petitioner asks this Court to disregard these prior admonitions by affixing conclusory labels to the foundations' activities and blindly applying the *per se* rule with no showing of "demonstrable economic effect."

Finally, as this Court noted in *White Motor Co. v. United States*, 372 U.S. 253, 263 (1963), (and reiterated, in substance, in *Broadcast Music*, 441 U.S. at 10, 16), "We need to know more than we do about the actual impact of these arrangements on competition to decide whether they have a 'pernicious effect on competition and lack . . . any redeeming virtue' [citation omitted] and therefore should be classified as *per se* violations of the Sherman Act." Similarly here, there has been too little

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[39]*Continental T. V.*, 433 U.S. at 47.

[40]*Id.* at 47, *quoting Appalachian Coals, Inc. v. United States*, 288 U.S. 344, 360 (1933).

[41]433 U.S. at 49-50.

[42]*Id.* at 58-59.

antitrust experience with the medical foundation concept of offering a lower cost alternative health insurance plan to blindly apply, as Petitioner would, a rigid *per se* analysis in the present case and the lower courts were correct in refusing to do so.

II. *Petitioner's Claim that the Ninth Circuit Created a New Burdensome or Impractical Standard of Proof is Erroneous.*

Notwithstanding Petitioner's claims, the Court of Appeals in no way required Petitioner to meet a new or unreasonably burdensome standard of proof. It only held that more evidence needed to be in the record before the trial court could determine if the Respondents' conduct should be found to be illegal price-fixing. Numerous decisions of this Court make it clear that not all horizontal agreements allegedly affecting price are *per se* unlawful. As discussed above, this Court rejected the simplistic approach to antitrust analysis favored by Petitioners in the *Broadcast Music* decision.

Catalano, Inc. v. Target Sales, Inc., 100 S. Ct 1925 (1980), cited extensively by Petitioners, is irrelevant to this action.[43] The *Catalano* case involved the question of characterization of an agreement among wholesalers to fix credit terms in which this Court held "credit terms must be characterized as an inseparable part of the

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[43]Respondents note in passing that the Petitioner appears to attempt to impugn the authority of the Ninth Circuit's decision in this action by implying that the reasoning of Judge Sneed should be rejected simply because *Catalano*, a case on which his decision in this action nowhere relied, was overruled. Such reasoning is, of course, spurious and improper.

price."[44] This Court ruled that the Ninth Circuit had erred in not making that characterization. In observing that "It has long been settled that an agreement to fix prices is unlawful *per se*. It is no excuse that the prices fixed are themselves reasonable."[45] this Court cited *United States v. Trenton Potteries Co., 273* U.S. 392, 397-98 (1927); *United States v. Trans-Missouri Freight Association,* 166 U.S. 290, 340-41 (1897); and *United States v. Socony-Vacuum Oil Co.,* 310 U.S. 150 (1940). In none of those cases did plaintiff prevail on a motion for summary judgment. In each instance, except the *Trans-Missouri Freight* decision, which only remanded the action for further proceedings after the complaint had been dismissed, a determination that the defendant's conduct was unlawful under the Sherman Act took place. But that determination was only made after completion of discovery and a trial on the merits. The same is true of *Sugar Institute v. United States,* 297 U.S. 553 (1936), *National Society of Professional Engineers v. United States,* 435 U.S. 679 (1978), *Federal Trade Commission v. Cement Institute,* 333 U.S. 683 (1948), and the other cases cited by this Court in support of its decision in *Catalano.*

This Court stated in *Catalano*: "when a particular concerted activity entails an obvious risk of anticompetitive impact with no apparent potentially redeeming value, the fact that a practice may turn out to be harmless in a particular set of circumstances will not prevent its being declared unlawful *per se*."[46] Note 8 to that decision made it clear that "Respondents nowhere suggest a pro-

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[44]100 S. Ct. at 1925.

[45]*Id.* at 1927.

[46]100 S. Ct. at 1928.

competitive justification for a horizontal agreement to fix credit. Their argument is confined to disputing that settled case law establishes that such an agreement is unlawful on its face."[47]

Unlike the situation in *Catalano*, Respondents in this action have suggested and argued below the procompetitive justification of offering an alternative to closed panel prepaid medical plans with foundation endorsed insurance, something which individual physicians could not separately attempt to do. Respondents further have suggested as a procompetitive justification that the effect of the foundation medical plans is to decrease the cost of medical service rather than to increase its cost and that this is done without any demonstrable effect upon the prices which physicians bill their patients. Additionally, the *Catalano* Court dealt with acts in a purely commercial industry. In contrast, in this action the challenged conduct concerns pricing in the medical profession. *See Veizaga v. National Board for Respiratory Therapy*, [1977-1] Trade Cas. (CCH) ¶61,274 (N.D. Ill. 1977) where the court denied plaintiff's motion for summary judgment, holding that determination of whether the questioned conduct was professional or commercial could not be made before trial.

The antitrust laws were not intended to straightjacket experimentation in fields such as the professions, not traditionally subject to antitrust scrutiny. In *Goldfarb* this Court went out of its way to state:

> "The fact that a restraint operates upon a profession as distinguished from a business is, of course, relevant in determining whether that

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[47] *Id.* at 1927.

> particular restraint violates the Sherman Act. It would be unrealistic to view the practice of professions as interchangeable with other business activities, and automatically to apply to the professions antitrust concepts which originated in other areas. The public service aspect, and other features of the professions, may require that a particular practice, which could properly be viewed as a violation of the Sherman Act in another context, be treated differently. We intimate no view on any other situation than the one with which we are confronted today."[48]

In *National Society of Professional Engineers*, this Court reiterated that "certain practices by members of a learned profession might survive scrutiny under the Rule of Reason even though they would be viewed as a violation of the Sherman Act in another context."[49] The decision then quoted in its entirety note 17 from *Goldfarb*.

In reality, Petitioner attempts to avoid *any* standard of proof, not merely a burdensome one. It would have this Court make a facile determination that Respondents' conduct is "price-fixing" and thus *per se* illegal, when both the District Court and the Ninth Circuit have found the evidence insufficient at this stage in the proceedings to support that determination.

Petitioner argues that the Ninth Circuit promulgated an impractical and unworkable standard, yet the majority opinion placed no added burdens on district courts. The Circuit Court recognized that in considering a complex and novel factual situation involving a profes-

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[48]421 U.S. at 788 n.17.

[49]435 U.S. at 686.

sion, summary judgment of liability based upon unreasoning application of *per se* rules would be unwise, when the court has not had the benefit of enough evidence to understand the consequences of the conduct which is challenged. The Ninth Circuit's decision merely requires Petitioner to prove that the Respondents' activities constituted anticompetitive price-fixing instead of assuming that as a theoretical matter in a factual vacuum. This is no greater an obstacle than has been overcome time and time again when a plaintiff challenges for the first time activities asserted to be illegally anticompetitive.

III. *Petitioner's Claim that a Conflict Has Been Created Between the Circuit Courts of Appeals Regarding the Per Se Illegality of Horizontal Price-Fixing Is Erroneous.*

Since the Ninth Circuit determined that it would not be proper to characterize Respondents' conduct as "price-fixing" on the record before it, it did not have to decide if horizontal price-fixing agreements that establish maximum prices constitute a *per se* violation. Unlike the situation in *Goldfarb*, where a mandatory minimum fee schedule with respect to prices to be charged for legal services was found to violate section 1, there is no proof of uniform pricing in this action. This Court stated in the *Goldfarb* decision:

> "A purely advisory fee schedule issued to provide guidelines, or an exchange of price information without a showing of an actual restraint of trade, would present us with a different question. . . ."[50]

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[50]421 U.S. at 781.

Thus, the only discussion of application of the *per se* rule to horizontal agreements fixing maximum prices in Judge Sneed's opinion is in footnote 4, where he states "[i]t is arguable that this case does not present the issue for our decision."[51] Judge Kennedy was silent on the issue.

The majority's determination was that the challenged conduct should not be characterized as price-fixing; not that horizontal maximum price-fixing is not a *per se* violation. Thus, the Ninth Circuit's opinion does not conflict with this Court's rulings in *Kiefer-Stewart Co. v. Joseph E. Seagram & Sons*, 340 U.S. 211, 213 (1951), *Albrecht v. Herald Co.*, 390 U.S. 145, 153 (1968), and *California Retail Liquor Dealers Association v. Midcal Aluminum, Inc.*, 445 U.S. 97 (1980) that maximum resale price-fixing is unlawful. Since the Circuit Court affirmed the denial of partial summary judgment without having to decide whether horizontal maximum price-fixing agreements should be *per se* violations, this Court has no conflict to resolve.

IV. *Petitioner's Claim That the Ninth Circuit Adopted Special Standard for Doctors Is Erroneous.*

The Ninth Circuit's decision follows logically from decisions of this Court. No "special standard for doctors" was created or even implied. The Court of Appeals followed *Goldfarb* and *National Society of Professional Engineers* which recognize that some degree of factual investigation concerning impact on competition and possible benefit to the public should be conducted before holding

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[51]Pet. App. A at 7.

a profession's activities to be *per se* price-fixing when they are subject to antitrust scrutiny for the first time.

The Ninth Circuit applied the "effect on competition" test expounded by this Court throughout the years, and recently restated in *National Society of Professional Engineers*, 435 U.S. at 690. Therefore, rather than adopting a radical special standard of liability for doctors as Petitioner claims, the Ninth Circuit cautiously followed the admonitions stated in recent decisions of this Court, admonitions especially appropriate to the denial, based upon the present insufficiency of the evidence, of a pre-trial motion for partial summary judgment on the issue of Respondents' antitrust liability based solely on Petitioner's characterization of Respondents' conduct.

Furthermore, no conflict exists between the circuit courts of appeal over a so-called doctors' exemption (or even the more general learned professions' exemption, a specter raised by Petitioner to create the appearance of conflict). The Ninth Circuit's determination that the evidence adduced at this point in the proceedings is insufficient to reverse the District Court's refusal to summarily adjudge a *per se* violation of the antitrust laws in view of the nature of the challenged conduct, the complexity of the industry and the involvement of a profession, conforms with the procedure followed in the cases cited by Petitioner. *See Virginia Academy of Clinical Psychologists v. Blue Shield of Virginia*, [1980-2] Trade Cas. (CCH) ¶63,395 (4th Cir. 1980)

The courts in those cases followed this same cautious path, determining whether there was *per se* liability only after the facts were completely adduced. *United States v. Utah Pharmaceutical Association*, 201 F. Supp. 29 (D. Utah), *aff'd*, 371 U.S. 24 (1962) (finding *per se* liability after fulsome discovery, stipulations and trial);

Feminist Women's Health Center, Inc. v. Mohammad, 586 F.2d 530 (5th Cir. 1978), *cert. denied*, 444 U.S. 924 (1979) (summary judgment for defendants found not proper because factual analysis showed that *per se* liability might, given more proof, apply); *United States v. National Society of Professional Engineers*, 555 F.2d 978, 980 (D.C. Cir. 1977), *aff'd*, 435 US 679 (1978) (applying *per se* liability only after "extensive discovery and trial"; *see also* this Court's analysis testing the Circuit Court's decision under the Rule of Reason); *Veizaga*, [1977-1] Trade Cas. (CCH) at 70,870 (the question of whether activities were subject to *per se* analysis was one of fact to be decided at trial and not on summary judgment.)[52] Since the Ninth Circuit followed the same approach in the instant litigation, no conflict exists for this Court to resolve.[53]

In summary, there is no special or important reason which would justify this Court's exercise of its discretion to grant the requested writ. The Ninth Circuit's decision created no new standard to apply to either hor-

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[52]The court in United States v. Texas State Bd. of Pub. Accountancy, 464 F. Supp. 400 (W.D. Tex. 1978), *aff'd*, 592 F.2d 919 (5th Cir.), *cert. denied*, 444 U.S. 925 (1979) found itself in the enviable position of facing a rule of a professional board virtually identical to that in *National Soc'y of Prof'l Eng'rs*. Thus, no factual analysis was necessary in the light of this Court's recent decision that such activity is properly characterized as price-fixing.

[53]Petitioner further posits that the Circuit Court's decision has generated some undefined uncertainty which must now be resolved by this Court. However, nowhere is this uncertainty given tangible meaning; it simply does not exist. The Ninth Circuit created no new "doctors' exemption" doctrine; it followed this Court's directives and it conformed to the manner in which the other circuits resolve whether the *per se* price-fixing characterization should be attached to questioned conduct. In any case, whatever "uncertainty" might conceivably exist will surely be resolved at trial.

izontal price-fixing agreements or doctors. The Circuit Court simply recognized that insufficient evidence has been brought forth to support Petitioner's characterization of Respondents' conduct as price-fixing which is a *per se* violation; thus, the matter should be tried before the liability issue can be decided.

This approach to the characterization of conduct as a *per se* violation comports with the rulings of this Court, creates no conflicts whatsoever between the rulings of the circuits, creates no unworkable standard burdensome to prosecutorial efforts and has not created such an uncertainty that might require this Court's attention on a writ of certiorari.

Respondents respectfully suggest that this litigation be permitted to follow its natural course and proceed to trial. At trial, sufficient evidence will be introduced to enable the trial court to determine if Respondents' activities present the anticompetitive dangers claimed by Petitioner and thus constitute "price-fixing," or if, as Respondents claim, the challenged conduct is beneficial to the public and has resulted in large savings in medical insurance premium costs without increasing medical fees.

CONCLUSION

Respondents respectfully ask this Court to deny the petition for writ of certiorari to the United States Court of Appeals for the Ninth Circuit for the reasons set forth in this Brief.

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No. 80-419

IN THE

Supreme Court of the United States

OCTOBER TERM, 1980

STATE OF ARIZONA,
Petitioner,

vs.

MARICOPA COUNTY MEDICAL SOCIETY,
MARICOPA FOUNDATION FOR MEDICAL CARE, and
PIMA FOUNDATION FOR MEDICAL CARE,
Respondents.

ON PETITION FOR A WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE NINTH CIRCUIT

REPLY MEMORANDUM FOR PETITIONER

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United States v. Socony-Vacuum Oil Co., 310 U.S. 150 (1940)	9
Williams v. St. Joseph Hospital, [1980-2] CCH Trade Cas. ¶63,438 (7th Cir. 1980)	9
Statutes:	
15 U.S.C. § 1	2
28 U.S.C. § 1292(b)	2

No. 80-419

IN THE

Supreme Court of the United States

OCTOBER TERM, 1980

STATE OF ARIZONA,
Petitioner,

vs.

MARICOPA COUNTY MEDICAL SOCIETY,
MARICOPA FOUNDATION FOR MEDICAL CARE, and
Pima Foundation For Medical Care,
Respondents.

ON PETITION FOR A WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE NINTH CIRCUIT

REPLY MEMORANDUM FOR PETITIONER

I.

RESPONDENTS' ATTEMPT TO CLOUD THE RECORD FLIES IN THE FACE OF THEIR OWN CONCESSIONS AND THE RULINGS OF THE LOWER COURTS AND MISPERCEIVES THE RATIONALE OF THE *PER SE* RULE

Respondents' efforts to cloud the factual record is a traditional tactic in opposing a petition for a writ of certiorari, but their efforts are refuted by their own concessions. Respondents themselves admit, "[T]he undisputed facts established an agreement among physicians who are members of a medical foundation that . . . each would accept as payment in full the amount paid by . . . insurance [endorsed

by that medical foundation]."[1] The foundations' endorsement turns on acceptance of the foundations' fee schedules (Jt. Br. in Opp. at 4), and under the foundations' by-laws their members "vote on the adoption of ... [those] uniform fee schedules."[2] The record is sufficiently clear therefore to warrant issuing the writ of certiorari.

The lower courts were unanimous in recognizing that what is involved here is a precise question of law and not—as respondents would have it—the adjudication of a factual dispute. The District Court, after all, certified its decision for interlocutory appeal under 28 U.S.C. § 1292(b) saying, "This Court's determination that the Rule of Reason approach should be used ... to determine whether a violation of Section 1 of the Sherman Act has occurred involves a question of law as to which there is substantial ground for difference of opinion ...."[3] The Court of Appeals unanimously accepted the section 1292(b) appeal, though it restated slightly the District Court's formulation of the issue: "[W]hether the [foundation] membership agreements, which contain the promise to abide by maximum fee schedules, are illegal *per se* under section 1 of the Sherman Act, 15 U.S.C. § 1." Pet. App. A at 2.

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[1] Joint Brief in Opposition to the State of Arizona's Petition for a Writ of Certiorari at *i* (hereinafter Jt. Br. in Opp.)

Respondents refer repeatedly to payments by health insurers and, while this is a convenient shorthand, it is somewhat lacking in precision. Under foundation-endorsed health plans, payments might be made either by health insurance companies or by major employers such as Motorola, Inc. or the State of Arizona which are sufficiently large that they do not need an intermediate insurance company to underwrite the actuarial risk. In any event, the foundation-endorsed health plans have deductible limits which must be met by the patient before any third-party reimbursement is made and payments against the deductible limits are made directly by the patients and not by any third-party.

[2] CR 106, Nos. 12, 13, 20, 21, 27, 28, 29.

[3] Petition for a Writ of Certiorari, Appendix F at 50 (hereinafter Pet. App.).

The section 1292(b) certifications by the lower courts are consistent with the traditional place of the *per se* rule in our antitrust jurisprudence. Beginning with *Standard Oil Co. v. United States*, 221 U.S. 1 (1911), and as recently as *National Society of Professional Engineers v. United States*, 435 U.S. 679 (1978), this Court has consistently held that certain agreements are so patently anticompetitive that no elaborate inquiry is required to hold them unlawful. This is the essence of the *per se* rule.

It may well be that the "uniform fee schedules" voted upon by the foundations' members are lower than those used by some health insurers and higher than those used by others. *See* Jt. Br. in Opp. at 11. Under the rule of reason and the *per se* rule, however, there must be the threshhold inquiry whether consideration of other fee schedules is necessary to decide the legality of the fee schedules agreed upon and used by the respondents and their members. So, too, with the matter of the competitive interaction of hospitals and health maintenance organizations, for example, and questions such as whether respondents have exacted the full measure of monopoly profits. *See* Jt. Br. in Opp. at 11. Concededly, none of these matters has been explored definitively in the present record, but the proper inquiry under the *per se* rule is whether analysis of these matters is necessary in order to judge the legality of respondents' adoption and use of agreed-upon fee schedules.

At least this much is clear and undisputed in the present record. Respondents and their members establish fee schedules for the individual medical services performed by respondents' members. Respondents' members are paid in

accordance with those agreed-upon fee schedules.[4] The issue which this Court must decide is whether those facts are sufficient to establish a *per se* violation of the Sherman Act or whether it is necessary to examine the full spectrum of the medical marketplace in order to rule respondents' conduct unlawful.

II.

THE NINTH CIRCUIT UNMISTAKEABLY RULED THAT THE REASONABLENESS OF AN AGREED-UPON PRICE IS A DEFENSE TO A PRIICE-FIXING CHARGE AND THIS RULING CREATES A CONFLICT WITH THE DECISIONS OF THIS COURT AND THE OTHER COURTS OF APPEALS WHICH SHOULD BE RESOLVED BY THIS COURT.

There is no question that this Court and the Courts of Appeals other than the Ninth Circuit have consistently rejected any defense to price-fixing charges based on the alleged reasonableness of the agreed-upon price. Perhaps recognizing that the Ninth Circuit's acceptance of such a defense would be grounds for summary reversal, respondents attempt to deny that the Ninth Circuit made any such ruling: "It did not rely on a reasonableness of price defense." Jt. Br. in Opp. at 13. With all due respect, it takes no more than a cursory review of the Ninth Circuit opinion

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[4] Respondents argue that "[t]his action does *not* involve an agreement by doctors on prices to charge their patients ...." Jt. Br. in Opp. at 1. The distinction respondents seem to be making is that they have agreed upon the "level of reimbursement," *e.g.*, *id.*, at 3, or the amount they will be paid by their patients and third-party payors rather than upon the prices they charge those patients and third-parties. This is a distinction without a difference.

If anything, the distinction respondents seek to draw is suggestive of greater price uniformity. In *United States v. National Association of Real Estate Boards*, 339 U.S. 485 (1950), the prescribed rates from the fee schedule were used in the great majority of transactions, although in exceptional circumstances a lower charge was made. Where, as here, the agreement is on the level of reimbursement rather that the quoted price, there is eliminated any incentive to deviate from the agreed-upon price even in "exceptional circumstances."

to demonstrate that the reasonableness of the agreed-upon price was, in fact, accepted as a defense to a price-fixing charge and that this aberrational ruling must be reviewed by this Court.

Contrary to respondents' argument, Judge Sneed did say, "The relevant inquiry becomes whether fees paid to doctors under that system would be less than those payable under the [foundations'] maximum fee agreement." Pet. App. A at 6. To make this "relevant inquiry," Judge Sneed suggested comparisons with other fee schedules used in the medical marketplace (Pet. App. A at 8-9); an analysis of respondents' own fee schedules to determine whether they were so high as "to capture a greater share of potential monopoly profit" (*id.*, at 6) or "sufficiently low to discourage entry by potential competitors" (*id.*, at 9); and a comparison of "the present supply and demand functions and those which would exist under ideal competitive conditions." *Id.*, at 6. All of these inquiries go to the reasonableness of the prices respondents have agreed upon. An analysis whether respondents' prices are "too high" or "too low" can have no purpose other than determing whether respondents' prices are reasonable. In the face of such explicit statements by Judge Sneed, respondents cannot argue that he "did not rely on a reasonableness of price defense."

The defense which the Ninth Circuit has allowed only serves to underscore the practical wisdom which has led this Court and every other Court of Appeals to reject the reasonableness of the price defense. It may be that the foundations' fee schedules implicated here are lower than

those that physicians have agreed upon for Blue Shield[5] or that the foundations themselves carry out in the State of Arizona's foster children program, but until now no antitrust defendant has ever been allowed to defend on the basis that some other conspiracy has established a still higher level of agreed-upon prices. This Court should reject this unprecedented defense recognized by the Ninth Circuit.

III.

IN LIGHT OF THEIR OWN CONCESSIONS AND THE FINDINGS OF THE LOWER COURTS, IT IS TOO LATE FOR RESPONDENTS TO ARGUE THAT THEIR AGREEMENTS ARE NOT AT LEAST MAXIMUM PRICE-FIXING.

In much the same vein as they argue that the Ninth Circuit did not endorse the reasonable price defense, respondents also argue that the lower courts "did not have to decide if horizontal price-fixing agreements that establish maximum prices constitute a *per se* violation." Jt. Br. in Opp. at 21. In light of their arguments to the lower courts and the findings of those courts, it is disingenuous for respondents to claim that the lower courts did not decide this question.

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[5] Justice Stewart's majority opinion in *Group Life & Health Ins. Co. v Royal Drug Co.*, 440 U.S. 205, 232 n.40 (1979) noted,

> Recent studies have concluded that physicians and other health care providers typically dominate the Boards of Directors of Blue Shield plans. Thus there is little incentive on the part of Blue Shield to minimize costs, since it is in the interest of the providers to set fee schedules at the highest possible level. This domination of Blue Shield by providers is said to have resulted in rapid escalation of health care costs to the detriment of consumers generally.

With a cloud already hanging over the legality and reasonableness of Blue Shield's fee schedules, the Blue Shield fee schedules are hardly a reliable benchmark for judging the legality or reasonableness of respondents' fee schedules.

In the District Court, for example, respondents relied heavily upon the affidavit of their executive director Anthony D. Mitten to show that their agreement set maximum fees.[6] The District Court accepted this argument. It said, "Based on the affidavit of Anthony D. Mitten, it is clear that the defendant Maricopa Foundation for Medical Care ... sets the maximum fees," Pet. App. D at 42, but the Court perceived "a recent antitrust trend ... emerging where the Rule of Reason is the preferred method of determining whether a particular practice is in violation of the antitrust law," *id.*, at 43, and therefore declined to apply this Court's *per se* rulings in *Kiefer-Stewart Co. v. Joseph E. Seagram & Sons, Inc.*, 340 U.S. 211 (1951), and *Albrecht v. Herald Co.*, 390 U.S. 145 (1968). Pet. App. D at 44.

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[6] We assume, for the sake of argument, that respondents' fee schedules set maximum rather than minimum fees, but there is much to argue that what is involved here is a minimum or uniform fee schedule. This Court, in *Albrecht v. Herald Co.*, 390 U.S. 145, 153 (1968), affirmed the principle that so-called ceilings on prices easily become floors:

> Moreover, if the actual price charged under a maximum price scheme is nearly always the fixed maximum price, which is increasingly likely, as the maximum price approaches the actual cost of the dealer, the scheme tends to acquire all the attributes of an arrangement fixing minimum prices.

The record here is clear that the purpose of the letters, polls and meetings among the foundations and their members was to set one price for any given service. For example, a letter from Maricopa Foundation for Medical Care's president, Dr. Lawrence J. Shapiro admits, "The Maricopa Foundation For Medical Care is interested in maintaining as close-as-possible a relationship between the maximum allowance for Foundation plans and the usual and customary charges made by physicians in this area." CR 7(b) Exhibit MF-33. (Appendix A hereto.) *See also* CR 7(b) Exhibits MF-3, MF-6 (Appendices B and C hereto) for further examples of the manner in which prices were set.

The result was the same in the Ninth Circuit. Before that Court, respondents argued that the maximum prices they had agreed upon were reasonable.[7] The Ninth Circuit accepted the District Court's finding that this was a "maximum fee agreement," Pet. App. A at 6, but declined to apply *Kiefer-Stewart* and *Albrecht* to this agreement, saying, "This circuit has not extended those rulings to horizontal agreements that establish maximum prices." Pet. App. A at 7 n.4. It is incorrect, then, to argue that the lower courts did not "decide if horizontal price-fixing agreements that establish maximum prices constitute a *per se* violation." Both of the lower courts did decide this question and they decided it contrary to the decisions of this Court and the other Courts of Appeals. Indeed, both of the lower courts expressly refused to follow this Court's decisions in *Kiefer-Stewart* and *Albrecht*.

IV.

THE NINTH CIRCUIT HAS CREATED A SPECIAL EXEMPTION FROM THE ANTITRUST LAWS FOR PHYSICIANS, AND THIS COURT MUST RESOLVE THE CONFLICT AMONG THE CIRCUITS.

The foundations' argument that the Ninth Circuit's decision does not impose a unique exemption for doctors and the health industry ignores the singular approach to price-fixing analysis taken by Judge Sneed for this industry:

> The health care industry, moreover, presents a particularly difficult area. The first step to understanding is to recognize that not only is access to the medical profession very time consuming and expensive both for

[7] "[T]he uncontroverted evidence establishes that at no time has Maricopa Foundation set a maximum reimburseable level of compensation for medical services ... in excess of what Maricopa Foundation's Board of Trustees believed to be the prevailing average or median usual and customary fee charged by physicians in Maricopa County for their services." Brief of Defendant-Appellee Maricopa Foundation for Medical Care at 28, *citing* CR 57, Mitten Affidavit, ¶ 6.

> the applicant and society generally, but also that numerous government subventions of the costs of medical care have created both a demand and supply function for medical services that is artificially high.

Pet. App. A at 6. Such solicitude for the particulars of an industry is not present in any other price-fixing case. *E.g., United States v. Socony-Vacuum Oil Co.*, 310 U.S. 150, 220 (1940) ("elimination of so-called competitive evils is no legal justification"). Certainly, the expense and time of entering the legal profession did not prevent this Court from finding in *Goldfarb v. Virginia State Bar*, 421 U.S. 773, 782-83 (1975), that "respondents' activities constitute a classic illustration of price fixing." As Judge Larson noted his dissent below, "[T]he situation with which the Court was confronted in *Goldfarb* — price fixing — is the same practice challenged in this case." Pet. App. at 21.

Moreover, the respondent foundations' only argument in rebuttal to petitioner's showing of a conflict between the Ninth Circuit's decision and the other Circuits is to say that there is not sufficient evidence in the record from which to find a *per se* violation. Jt. Br. in Opp. at 23. Such a position cannot stand in light of both the record in this case and the proper application of the *per se* rule. *See* section II, *supra*.

Contrary to the foundations' bald assertion that the circuits are not in conflict as a result of the Ninth Circuit's opinion, two recent cases demonstrate that the controversy is current and ongoing. In *Williams v. St. Joseph Hospital*, [1980-2] CCH Trade Cas. ¶63,438, at 76,290 (7th Cir. 1980), the Seventh Circuit, citing *Goldfarb*, stated that "later cases indicate plainly that with regard to its economic aspects professional activity is subject to the policies of the antitrust laws." In addition, the Second Circuit just recently upheld the Federal Trade Commission's restrictions on physician advertising, *American Medical Association v. Federal Trade Commission*, [1980-2] CCH Trade Cas.

¶63,568 (2d Cir. 1980), which restrictions are grounded on basic antitrust conspiracy law as set forth in *Goldfarb*. In the *Matter of American Medical Association*, CCH Trade Reg. Rep. ¶21,068 (1979).

CONCLUSION

For the reasons set forth herein and in the petition, the petition for writ of certiorari should be granted.

Respectfully submitted,

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By _____

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Phoenix, Arizona 85003
(602) 255-4751
Counsel for Petitioner

Appendix A

M[illegible]RICOPA FOUNDATION FOR ME[illegible]AL CARE

ACADEMY OF MEDICINE
2601 NORTH CENTRAL AVENUE
PHOENIX, ARIZONA 85004

TELEPHONE: [illegible]

President
Lawrence J. Shapiro, M.D.
Vice President
William Myers, M.D.
LeRoy P. Graves, D.C.
Treasurer
Rodger Hart, M.D.
Secretary
Patrick P. Moreno, M.D.
Trustees
Joseph Bier, M.D.
Norman Brown, M.D.
James Campbell, M.D.
William Cook, M.D.
Richard Daley, M.D.
Robert Disarro, M.D.
Robert L. Fox, M.D.
James Giangobbe, M.D.
Keith Harris, M.D.
David Hirshorn, M.D.
James Loughorn, M.D.
Donald Miles, M.D.
Laurence Nolan, M.D.
Richard Pennington, M.D.
William Ragsdale, M.D.
Ronald Surer, M.D.
Executive Director
Anthony D. Moran, J.D.
Administrative Director
Bruce M. Lefler

April 14, 1977

Truman Plainer, M.D.
President
Arizona Ophthalmological Society
2600 South Rural Road
Tempe, Arizona 85282

Dear Doctor Plainer:

The Maricopa Foundation For Medical Care is interested in maintaining as close-as-possible a relationship between the maximum allowance for Foundation plans and the usual and customary charges made by physicians in this area.

To that end we would ask you to review with members of your specialty group the present Foundation conversion factors (attached) and advise us as to any changes you feel would be appropriate either on an overall conversion factor change or specific procedures where your group feels the payments are inequitable.

We hope by these means to keep the Foundation concept viable in this community in protecting the private practice, free choice of physician method of health care delivery.

We would appreciate receiving this information from your organization by June 10, 1977.

Sincerely,

Lawrence J. Shapiro, M.D.
PRESIDENT

LJS/jtm

Established as a service to the community by the Maricopa County Medical Society

EXHIBIT NO. ME-33

Appendix B

MARICOPA FOUNDATION FOR MEDICAL CARE

ACADEMY OF MEDICINE
[redacted] NORTH CENTRAL AVENUE
PHOENIX, ARIZONA [redacted]

TELEPHONE [redacted]

President
[redacted]
Vice Presidents
[redacted]
Treasurer
[redacted]
Secretary
[redacted]
Trustees
[redacted]
Executive Director
[redacted]
Administrative Director
[redacted]

June 7, 1977

To: All Foundation Members

Dear Doctor:

The Foundation is in the process of reviewing its Minimum Standards and we feel it is time to survey the entire Foundation membership for their opinions concerning our fee schedule. While we do not feel that the Foundation Fee Schedule can be considered usual and customary for this area we do feel strongly that it should approximate the majority of physician charges.

In order to arrive at a reasonable consensus we need your prompt response to the enclosed post card questionnaire. As soon as we tabulate this poll you will receive a ballot asking for your approval of any changes in the Foundation Fee Schedule.

We appreciate your early response to this questionnaire and look forward to your continued support and cooperation.

Sincerely,

Lawrence J. Shapiro, M.D.
PRESIDENT

LJS/jtm

Enclosure

Established as a service to the community by the Maricopa County Medical Society

EXHIBIT NO. ME-3

Appendix C

UROLOGY ASSOCIATES, LTD
FIFTH AVENUE MEDICAL BUILDING
PHOENIX, ARIZONA

May 26, 1977

Lawrence J. Shapiro, M.D.
President, Maricopa Foundation for Medical Care
2025 North Central Avenue
Phoenix, Arizona 85004

Dear Larry:

This is in response to your letter to me as President of the Phoenix Urological Society in reference to the customary charges of urologists in this community.

I did not really know how to answer this, short of polling the members at our meeting two days ago as to what their usual and customary charges were. Using the equivalent of the '64 California Relative Value Scale, most of the physicians were 10 to 11 with a few at 12, and only one physician was 9.5.

I think without reservation one could say that your present charge of 9.5 dollars per unit is less than what most physicians are presently charging.

The one operation that most urologists feel is inadequately reimbursed is the Marshall-Marchetti procedure which is allowed 40 units, and most physicians are charging 60 units, based on the fee schedule of the AUA, which in most procedures is essentially the same as the '64 California Relative Value Scale.

Hoping the above answers your questions,

Sincerely yours,

Sherwood E. Denton, M.D.

SED:mh

EXHIBIT NO. ME-6

FILED
SEP 29 1980
MICHAEL RODAK, JR., CLERK

No. 80-419

IN THE

Supreme Court of The United States

OCTOBER TERM, 1980

STATE OF ARIZONA,
Petitioner,

vs.

MARICOPA COUNTY MEDICAL SOCIETY,
MARICOPA FOUNDATION FOR MEDICAL CARE, and
PIMA FOUNDATION FOR MEDICAL CARE,
Respondents.

ON PETITION FOR A WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE NINTH CIRCUIT

BRIEF FOR THE STATES OF ALABAMA, ALASKA, ARKANSAS, COLORADO, CONNECTICUT, DELAWARE, FLORIDA, HAWAII, ILLINOIS, INDIANA, IOWA, KANSAS, LOUISIANA, MAINE, MARYLAND, MICHIGAN, MINNESOTA, MISSISSIPPI, MISSOURI, MONTANA, NEBRASKA, NEVADA, NEW HAMPSHIRE, NEW JERSEY, NEW MEXICO, NEW YORK, NORTH CAROLINA, NORTH DAKOTA, OHIO, OKLAHOMA, OREGON, RHODE ISLAND, SOUTH DAKOTA, TENNESSEE, TEXAS, UTAH, VERMONT, WASHINGTON, WEST VIRGINIA, WISCONSIN, WYOMING, AND THE COMMONWEALTHS OF KENTUCKY AND MASSACHUSETTS AS *AMICI CURIAE* IN SUPPORT OF THE PETITIONER

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QUESTION PRESENTED

Is an agreement among competing physicians establishing fee schedules for their individual services a per se violation of section 1 of the Sherman Act?

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No. 80-419

IN THE

Supreme Court of The United States

OCTOBER TERM, 1980

STATE OF ARIZONA,

Petitioner,

vs.

MARICOPA COUNTY MEDICAL SOCIETY, MARICOPA FOUNDATION FOR MEDICAL CARE, and PIMA FOUNDATION FOR MEDICAL CARE,

Respondents.

ON PETITION FOR A WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE NINTH CIRCUIT

BRIEF FOR THE STATES OF ALABAMA, ALASKA, ARKANSAS, COLORADO, CONNECTICUT, DELAWARE, FLORIDA, HAWAII, ILLINOIS, INDIANA, IOWA, KANSAS, LOUISIANA, MAINE, MARYLAND, MICHIGAN, MINNESOTA, MISSISSIPPI, MISSOURI, MONTANA, NEBRASKA, NEVADA, NEW HAMPSHIRE, NEW JERSEY, NEW MEXICO, NEW YORK, NORTH CAROLINA, NORTH DAKOTA, OHIO, OKLAHOMA, OREGON, RHODE ISLAND, SOUTH DAKOTA, TENNESSEE, TEXAS, UTAH, VERMONT, WASHINGTON, WEST VIRGINIA, WISCONSIN, WYOMING, AND THE COMMONWEALTHS OF KENTUCKY AND MASSACHUSETTS AS *AMICI CURIAE* IN SUPPORT OF THE PETITIONER

INTEREST OF AMICI CURIAE

The States of Alabama, Alaska, Arkansas, Colorado, Connecticut, Delaware, Florida, Hawaii, Illinois, Indiana, Iowa, Kansas, Louisiana, Maine, Maryland, Michigan, Minnesota, Mississippi, Missouri, Montana, Nebraska, Nevada, New Hampshire, New Jersey, New Mexico, New York, North Carolina, North Dakota, Ohio, Oklahoma, Oregon, Rhode Island, South Dakota, Tennessee, Texas, Utah, Vermont, Washington, West

Virginia, Wisconsin, Wyoming, and the Commonwealths of Kentucky and Massachusetts respectfully submit this brief *amici curiae* in support of Arizona's petition for a writ of certiorari to the United States Court of Appeals for the Ninth Circuit in accordance with Supreme Court Rule 36.

The *amici* states represent nearly every sovereign state in the Union and the respective chief law enforcement officers of those states who are charged with the responsibility of enforcing state antitrust guidelines modeled, for the most part, on the Sherman Act. [1] These various state antitrust laws are judicially construed in a manner consistent with this Court's interpretation of federal antitrust laws. [2] Accordingly, the decision of the Ninth Circuit may impact directly on the states' ability to prevent unreasonable restraints of trade and commerce within their borders.

The attorneys general of the *amici* states, as counsel to professional licensing boards, have the responsibility of advising those regulators whether horizontal price agreements among medical and other professionals violate the antitrust laws. Because the decision of the Ninth Circuit Court of Appeals raises serious doubt as to whether the conduct of certain professions is exempt from the antitrust laws, it has caused great uncertainty as to what advice regarding horizontal price agreements may be appropriate.

Only recently, the United States Congress enhanced the states' role in antitrust enforcement by authorizing substantial appropriations for the purpose of developing or expanding each state attorney general's enforcement capability. 42 U.S.C. § 3701. The signifi-

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[1] *E.g.*, Neb. Rev. Stat. § 59-801 (Cum. Supp. 1978).

[2] *E.g.*, *State v. Milwaukee Braves, Inc.*, 31 Wis.2d 699, 716, 144 N.W.2d 1, 9 (1966).

cance of the state attorneys generals' position in assuring nationwide antitrust compliance was recognized further by federal legislation which authorized the states to sue as *parens patriae* to recover damages for citizens injured by violations of the Sherman Act. 15 U.S.C. § 15(c). Against this tapestry of increased federal concern for viable state antitrust enforcement is the ironic consequence of the Ninth Circuit decision: increased medical costs to Arizona's citizens and also to the state which reimburses for medical expenses incurred from health care insurance; a result which impedes the efforts of state antitrust officials.

Clearly, the *amici* states have direct and substantial interests which are jeopardized by a decision which establishes a separate standard of antitrust liability for doctors and the medical care industry. And the reasoning employed by the circuit court in arriving at this decision has cast a cloud of uncertainty over previously established principles of antitrust decisional law.

QUESTION PRESENTED

Is a horizontal agreement among competing physicians establishing fee schedules for their individual services a per se violation of section one of the Sherman Act?

STATUTORY PROVISION INVOLVED

Section one of the Sherman Act, 15 U.S.C. § 1, provides in pertinent part:

> Every contract, combination, in the form of trust or otherwise, or conspiracy, in restraint of trade or commerce among the several States, or with foreign nations, is declared to be illegal.

STATEMENT OF THE CASE

The petitioner State of Arizona filed this antitrust ac-

tion for declaratory and injunctive relief on its own behalf and, as *parens patriae,* on behalf of Arizona's citizens pursuant to 28 U.S.C. §§ 1331 and 1337 and section 16 of the Clayton Act, 15 U.S.C. § 26.

The respondents are three private trade associations of doctors, established by medical societies in Maricopa and Pima County to promote the practice of fee-for-service medicine in Arizona. These respondents, the Maricopa County Medical Society, the Maricopa Foundation for Medical Care, and the Pima County Foundation for Medical Care include in their membership more than 1,000 doctors in Maricopa County and more than 400 Pima County physicians, substantial proportions of the practicing physicians in Arizona's two most populous counties.

The respondent foundations prepared and adopted physician fee schedules which established fees to be charged for nearly all medical procedures performed by the member doctors. From 85 to 95 percent of the foundation members charged their patients at or above the fee schedule rates. To further assure uniform payment for their services, the foundations' members agreed to accept the prices fixed by their fee schedules as full reimbursement for services covered by foundation endorsed health insurance plans.

Widespread meetings, discussions and agreements among the membership preceded any uniform increase in the compensation rates established by the foundation fee schedules. After adoption by the membership, these fee schedules were published and circulated to both member and nonmember doctors throughout Arizona, provoking an inflationary effect on medical costs generally. Advance notice of the periodic schedule increases was provided to foundation-approved underwriters, allowing them to increase the

insurance premiums necessary to offset the added expenses.

Member doctors threatened to leave the foundation unless the fixed and scheduled rates were increased, a blatant indication that fees for individual services were collectively controlled and could not be adjusted by individual doctors or insurers.

Following discovery which established the facts set forth above, [3] the State of Arizona moved for partial summary judgment on the issue of liability. On June 5, 1979, the district court denied that motion on the ground that the price agreements at issue should be analyzed under the rule of reason. [4]

On August 6, 1979, pursuant to 28 U.S.C. § 1292 (b), the district court granted the petitioner's motion for certification for interlocutory review of the court's ". . . determination that the Rule of Reason approach should be used in analyzing the challenged conduct." [5]

The Ninth Circuit Court of Appeals granted permission to appeal and consolidated the § 1292(b) appeal with Arizona's pending appeal of the district court's vacation of an interlocutory injunction. The appeals panel stayed the district court order, and enjoined the respondents from establishing a new fee schedule pending appeal.

In a two to one decision, the court of appeals entered an order on November 19, 1979 which affirmed the district court's decision and dissolved the Ninth Circuit stay. On March 20, 1980, the court of appeals issued its opinion. [6]

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[3] Petitioner's Statement of the Case at 2-5.
[4] Petitioner's Appendix D.
[5] Petitioner's Appendices E & F.
[6] Petitioner's Appendix A.

The State of Arizona seeks review on the question of whether the respondents' horizontal price agreement constitutes price fixing which is illegal per se under section one of the Sherman Act.

REASONS FOR GRANTING THE WRIT

A. Neither Congress nor the Supreme Court has Recognized the Ninth Circuit's "Reasonable Price" Defense to Horizontal Price Fixing.

The statutory provision directly at issue in this case is section one of the Sherman Act, 15 U.S.C. § 1. However, the Court must be mindful that its interpretation of this provision will reach far beyond the limits of the federal law. The *amici* states have identical or similar "Sherman Act" provisions in their local antitrust laws which will be interpreted by state judges in accordance with federal court decisions.[1] Consequently, the states' ability to enforce antitrust law compliance under both federal and state law is jeopardized by the decision of the Ninth Circuit.

Section one of the Sherman Act simply and clearly states that contracts, combinations, or conspiracies which restrain trade or commerce are illegal. Whether or not such agreements or trusts caused the

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[1] For example, Neb. Rev. Stat. § 59-829 (Cum. Supp. 1978) provides as follows:

> When any provision of sections 59-821, 59-828, 59-829, and 84-214 or any provision of Chapter 59 is the same as or similar to the language of a federal antitrust law, the courts of this state in construing sections 59-821, 59-828, 59-829, and 84-211 to 84-214 or any provision of Chapter 59 shall follow the construction given to the federal law by the federal courts.

And Neb. Rev. Stat. § 59-1603 (Cum. Supp. 1978) provides that "[A]ny contract, combination, in the form of trust or otherwise, or conspiracy in restraint of trade or commerce shall be unlawful."

Accord, e.g., Ill. Rev. Stat., ch. 38, § 60-30, et seq. (1979); 6 Del. Code Ann. § 2113 (Supp. 1979); Md. Com. Law Code Ann. § 11-202(a)(2) (1975).

establishment of minimum, maximum, or even "reasonable" prices, the statute makes no exception for the result achieved by the illegal act. As this Court very recently reaffirmed, the Sherman Act's ban against horizontal combinations which fix prices among competing providers of goods or services cannot be justified by a defense of "reasonable" economic impact.

> A horizontal agreement to fix prices is the archetypal example of such a practice. It has long been settled that an agreement to fix prices is unlawful *per se. It is no excuse that the prices fixed are themselves reasonable.*

Catalano, Inc. v. Target Sales, Inc., ___ U.S. ___, 100 S.Ct. 1925, 1927 (1980) (Emphasis supplied).

The Ninth Circuit's decision in the instant case preceded this Court's clear delineation of the standard for per se analysis as set forth above. Perhaps this is why Judge Sneed, after finding that the respondent foundations' fee schedules had indeed fixed the price of medical services, was reluctant to conclude such an arrangement was illegal per se. Rather, the majority opinion relied upon language in this Court's decision in *National Society of Professional Engineers v. United States,* 435 U.S. 679 (1978), as holding that the crucial determination of whether such a horizontal agreement violates the Sherman Act depends on its "impact on competitive conditions." * But the foregoing phrase taken from this Court's discussion of the historical antecedents of the rule of reason analysis in *Professional Engineers* was taken out of the context of the holding. The discussion of the rule of reason standard in *Professional Engineers* occurred because the trade restraint at issue was not the fixing of prices, but rather an association restriction on competitive bidding, a practice ancillary to commercial transactions; a practice af-

* Petitioner's Appendix A at 4.

fecting, but not directly establishing prices. But the holding of this Court was "the Rule of Reason does not support a defense based on the assumption that competition itself is unreasonable." *Id.* at 696. Allowing such a defense would fly in the face of the legislative judgment reflected in the Sherman Act which embraces the reasoning that competition assures lower prices and, further, "precludes [judicial] inquiry into the question whether competition is good or bad." *Id.* at 695. Consequently, the Court's opinion in *Professional Engineers* directs that the rule of reason analysis *should not* be employed when the trade restriction results in the fixing of rates or prices by private agreement. *

> The Rule of Reason suggested by *Mitchell v. Reynolds* has been regarded as a standard for testing the enforceability of covenants in restraint of trade which are ancillary to a legitimate transaction, such as an employment contract or the sale of a going business. Judge (later Mr. Chief Justice) Taft so interpreted the Rule in his classic rejection of the argument that competitors may lawfully agree to sell their goods at the same price as long as the agreed-upon price is reasonable. *United States v. Addyston Pipe & Steel Co.* 85 F. 271, 282-283 (CA6 1898), aff'd, 175 U.S. 211. *That case,* and subsequent decisions by this Court, *unequivocally foreclose an interpretation of the Rule as permitting an inquiry into the reasonableness of the prices set by private agreement.*

Id. at 689 (Emphasis supplied).

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* The Court in *Catalano* later affirmed the nonapplicability of the rule of reason in *Professional Engineers,* stating that:

> [A]n agreement among competing firms of professional engineers to refuse to discuss prices with potential customers until after negotiations have resulted in the initial selection of an engineer was held unlawful without requiring further inquiry.

Catalano, supra, 100 S.Ct. at 1928.

Similarly, while holding that the blanket copyright licenses at issue in *Broadcast Music, Inc. v. Columbia Broadcasting System, Inc.*, 441 U.S. 1 (1979), did not directly fix prices, this Court again reaffirmed that "agreements among competitors to fix prices on their individual goods and services are . . . within the *per se* category." *Id.* at 8.

The refusal of the Ninth Circuit majority to apply the per se rule had "other roots," apparently revealed in footnote four of the opinion. [10] Therein the lower court suggested that decisional law is unsettled on the question of whether per se rules should apply to horizontal maximum price agreements. To the contrary, this Court has held that combinations fixing maximum prices are illegal per se. In *Kiefer-Stewart Company v. Joseph E. Seagram & Sons, Inc.*, 340 U.S. 211 (1951), where both horizontal and vertical price fixing aspects were present, the Court concluded:

> [A]greement[s] among competitors to fix maximum resale prices . . . no less than those to fix minimum prices, cripple the freedom of traders and thereby restrain their ability to sell in accordance with their own judgment. We reaffirm what we said in *United States v. Socony-Vacuum Oil Co.*, 310 U.S. 150, 223: "Under the Sherman Act a combination formed for the purpose and with the effect of raising, *depressing*, fixing, pegging, or *stabilizing* the price of a commodity . . . is illegal *per se*."

Id. at 213 (Emphasis supplied).

The Court later affirmed its holding in *Albrecht v. Herald Company*, 390 U.S. 135 (1968), which found maximum price fixing illegal per se. And the case at bar clearly illustrates the practical effects of such maximum price schedules. From 85 to 95 percent of the member physicians charged prices which either

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[10] Petitioner's Appendix A at 7, n. 4.

equaled or *exceeded* the rates set by the foundation fee schedules. [11] As Judge Larson aptly noted in his dissent, the cost control justification for such maximum fee schedules "is illusory and nonexistent." [12]

The Ninth Circuit majority has clearly misapplied these recent decisions of the Court to a case of blatant horizontal price fixing. If allowed to stand, the decision of the circuit court will be read as creating a new defense to the charge of price fixing, and will further erode the clear mandate of section one of the Sherman Act.

B. Neither Congress nor the Supreme Court has Recognized a Separate Standard of Antitrust Liability for Services Provided by the "Learned Professions" in Cases Involving Direct Restraints on Prices.

The majority opinion of the court of appeals concluded by drawing comfort from this Court's "reiteration [13] . . . that marketing restraints that regulate professional competition may pass muster under the Rule of Reason even though similar restraints on ordinary business competition would not." [14] Such comfort is warranted only if this Court accepts the Ninth Circuit's apparent attempt to regard price fixing as no different than any other type of market restraint.

However, this Court has not recognized a special standard for professional services in cases involving

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[11] Petitioner's Statement of the Case at 4.

[12] Petitioner's Appendix A at 31.

[13] The "reiteration" is apparently a reference to this Court's discussion of the Sherman Act's application to the commercial activity of the learned profession in *National Society of Professional Engineers, supra,* and *Goldfarb v. Virginia State Bar,* 421 U.S. 773 (1975).

[14] Petitioner's Appendix A at 12.

direct price restraints. Fee schedules were found to be "a classic illustration of price fixing" in *Goldfarb*, 421 U.S. 773, 783 (1975), and the rule of reason standard was not employed. In *Professional Engineers*, the Court clarified, by case example, why price restraints cannot be analyzed in the same fashion as other types of free market restrictions.

> Price is the "central nervous system of the economy," *United States v. Socony-Vacuum Oil Co.*, 310 U.S. 150, 226 n. 59, and an agreement that "interfere[s] with the setting of price by free market forces" is illegal on its face. *United States v. Container Corp.*, 393 US 333, 337. In this case we are presented with an agreement among competitors to refuse to discuss prices with potential customers until after negotiations have resulted in the initial selection of an engineer. While this is not price fixing as such, no elaborate industry analysis is required to demonstrate the anticompetitive character of such an agreement.

National Society of Professional Engineers, supra, 435 U.S. at 692.

These two cases, cited by the Ninth Circuit majority as suggesting a "professional services immunity" from the per se standard of antitrust liability, illustrate just the opposite. [15] Both of these decisions reaffirm what the Sherman Act directs: a judicial focus upon the particular anticompetitive practice at issue as opposed to an analysis of an entire industry. Both

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[15] Moreover, as petitioner Arizona noted, the Ninth Circuit's recognition of a special standard of antitrust liability for doctors creates a conflict among the circuits on the question of applying per se rules to price restraints by professional groups. The application of the per se rule in *Ballard v. Blue Shield of Southern West Virginia, Inc.*, 543 F. 2d 1075 (4th Cir. 1976), *cert. denied*, 430 U.S. 922 (1977) and *United States v. National Society of Professional Engineers*, 555 F.2d 978 (D.C.Cir. 1977), *aff'd*, 435 U.S. 679 (1978) underscores the conflict and presents another compelling reason for the Court to grant certiorari in this case.

cases firmly reiterate this Court's respect of the Sherman Act's unequivocal ban on price fixing, regardless of the occupation of the offenders or the economic impact of the offense.

C. The Majority Opinion of the Ninth Circuit Impedes Effective Enforcement of State Antitrust Laws.

A "reasonable price" defense to horizontal price fixing, as apparently recognized by the Ninth Circuit, will effectively curtail the ability of state antitrust enforcement divisions to preserve the free market forces of the economy. Prior to the opinion at issue here, the matter of economic impact resulting from a horizontal conspiracy to set prices was relevant only to the question of damages. If a professional group of private doctors who agree to uniform fee schedules are not liable unless the state can establish the fixed rates are unreasonable, it simply will not be practical to prosecute such cases.

Injunctive relief is a powerful enforcement tool given the limited resources of the state attorneys general. For the average private citizen, unable to afford the cost of private antitrust litigation, reliance on governmental antitrust enforcement is critical. In Arizona, the injunction dissolved by the Ninth Circuit now removes the only protection afforded the general citizenry from the inflated costs of a medical care industry accounting for 10 per cent of Arizona's Gross State Product. [16]

The Ninth Circuit opinion not only renders impractical the states' ability to prosecute horizontal price fixing, but also casts doubt on the proper standards for state officials to follow in regulating professional serv-

[16] Exhibit D to CR 68; CR 13, 14, 109.

ices. If the "learned professions" can fix "reasonable" price standards, are state bar associations now free to poll their membership and adopt maximum fee schedules? Should state workmen compensation courts turn to the state medical associations for guidance in awarding reasonable damages? May brokers use the state real estate commission as a conduit for establishing uniform fee guidelines?

The ability of the *amici* states and their attorneys general to properly advise these state officials has been eroded by the legal uncertainties created by the circuit opinion. But the ultimate victims of a decision which carves a special exemption for professional services will be the citizens and consumers we represent.

The *amici* states share the concern of this Court [17] and Congress [18] over the astronomical rise in medical provider costs during the past decade. It is respectfully submitted that removing the health care industry from the competitive forces of a free marketplace will simply increase those costs.

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[17] *Group Life & Health Ins. Co. v. Royal Drug Co., Inc.*, 440 U.S. 205, 232 n. 40 (1979).

[18] *E.g., Skyrocketing Health Care Costs: The Role of Blue Shield: Hearing Before the Subcommittee on Oversight and Investigations of the House Committee on Interstate and Foreign Commerce*, 95th Cong., 2d Sess., 4-34 (1978). (Remarks of Michael Pertschuk, Chairman, Federal Trade Commission.)

CONCLUSION

For the foregoing reasons, the *amici* states respectfully submit that the State of Arizona's petition for writ of certiorari should be granted.

Dated this 26th day of September, 1980.

Respectfully submitted,

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IN THE

Supreme Court of the United States

October Term, 1980

No. 80-419

STATE OF ARIZONA,

Petitioner,

against

MARICOPA COUNTY MEDICAL SOCIETY,
MARICOPA FOUNDATION FOR MEDICAL CARE, and
PIMA FOUNDATION FOR MEDICAL CARE,

Respondents.

ON A PETITION FOR A WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE NINTH CIRCUIT

MOTION FOR LEAVE TO FILE BRIEF AMICI CURIAE AND BRIEF AMICI CURIAE OF THE AMERICAN ASSOCIATION OF RETIRED PERSONS AND THE NATIONAL RETIRED TEACHERS ASSOCIATION IN SUPPORT OF THE PETITIONER

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ON A PETITION FOR A WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE NINTH CIRCUIT

MOTION FOR LEAVE TO FILE BRIEF AMICI CURIAE IN SUPPORT OF THE PETITIONER AND STATEMENT OF INTEREST OF AMICI CURIAE

The American Association of Retired Persons (AARP) and the National Retired Teachers Association (NRTA), of 1909 K Street, N.W., Washington, D.C. 20049, respectfully move the Court pursuant to Rule 36 of the Rules of the United States Supreme Court for permission to file the attached brief amici curiae on a Petition for a Writ of Certiorari to the United States Court of Appeals for the Ninth Circuit. The grounds for this motion, which grounds also disclose the interest of the amici, are set forth below.

AARP and NRTA are affiliated and jointly administered not-for-profit membership corporations of more than

12,500,000 persons over the age of 55. This figure represents approximately one out of four people over the age of 55 nationwide, the largest organized group of older Americans in the country. Among the purposes of AARP are: to enhance the quality of life for older persons; to promote independence, dignity and purpose for older persons; to lead in determining the role and place of older persons in society; and to improve the image of aging. Among the purposes of NRTA are: to promote the social welfare, and needs of retired teachers, administrators, and all other persons eligible for membership; to improve the quality of life for retired teachers, school administrators, and all older Americans, to the end that aging is achieved with independence, dignity and purpose; and to sponsor research on physical, psychological, social, economic and other aspects of aging.

AARP and NRTA, together, have over 182,000 members in the State of Arizona. A total of 289,000 people over 65 live in Arizona, making up 11.8% of the state's population. Arizona's elderly population is growing more rapidly than that of any other state.

The State of Arizona filed its Petition for a Writ of Certiorari to the United States Court of Appeals, not only on its own behalf, but as *parens patriae* on behalf of its resident natural citizens, seeking reversal of the denial of declaratory and injunctive relief against the establishment and use of uniform and agreed upon schedules by medical doctors in violation of § 1 of the Sherman Act, 15 U.S.C. § 1. The question presented by the Petition is whether an agreement among competing physicians establishing fee schedules for their individual services is a *per se* violation of Section 1 of the Sherman Act.

As retired persons, members of AARP and NRTA generally live on relatively fixed incomes and, because of their

advanced age, many also depend on regular or frequent health care for their continued well being. Because of the need to limit the already high, and rapidly increasing, cost of health care, including physicians' fees, this case is especially critical to the health and welfare of AARP and NRTA members and of all older Americans.

The elderly spend a far greater amount *per capita* on health care each year than younger persons. In 1979, the average annual health care expenditure for persons over 65 was $2,257 or 3½ times the average amount for citizens under 65. While older Americans comprise only 11.2% of the population, they spend 29% of the total nationwide expenditure for personal health care.[1]

In 1979, $40.6 billion, or 19% of total national health care expenditure went directly for doctors' bills, approximately $180 per person. Persons over the age of 65 visit a physician an average of 6.3 times per year compared with the average of 4.8 times for individuals generally.[2] The elderly require physicians' services not only more frequently, but for more complicated and therefore more expensive treatment than the average individual.

Compounding the rate of increase in doctors' fees is the increase in out-of-pocket costs to older Americans for services rendered by these doctors. Only 46% of physicians accept Part B medicare reimbursement as payment in full for their services. Older Americans must assume substantial costs in the form of Medicare deductibles, coinsurance and fees in excess of the Medicare "reasonable-charge" reimbursements for doctors' services. For Americans over the age of 65, a full 41.8% of physicians' services are paid for privately.[3]

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1. Gibson, *National Health Expenditures 1979*, 2 HEALTH CARE FINANCING REVIEW 1 (Summer 1980); Fisher, *Differences By Age Groups in Health Care Spending*, 1 HEALTH CARE FINANCING REVIEW 4 (Spring 1980).
2. *Id.*
3. *Id.*

Indeed, precisely because of their concern over the high cost of medical care, and specifically the anti-competitive nature of the health care industry of which physicians form a significant segment, amici and their members have worked to promote and encourage competition in the health care marketplace and to make competition among providers a priority in health planning.

Since the over 12.5 million members of the amici (182,000 in Arizona alone), are directly and severely affected by the cost of health care, and because AARP and NRTA have been in the forefront of the battle to open up and stimulate competition in the health care market place, amici have a vital interest in the question of whether an agreement among physicians, fixing prices for their individual services, is a *per se* violation of the Sherman Act.

The amici have been unable to obtain the consent of the respondents to the filing of the attached brief, thus necessitating this motion.

WHEREFORE, AARP and NRTA respectfully move for permission to file the attached brief amici curiae in support of the Petition for a Writ of Certiorari in this matter.

Respectfully submitted,

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IN THE

Supreme Court of the United States

October Term, 1980

No. 80-419

STATE OF ARIZONA,

Petitioner,

against

MARICOPA COUNTY MEDICAL SOCIETY, et al.,

Respondents.

BRIEF AMICI CURIAE IN SUPPORT OF THE PETITIONER

Introduction

The overriding interest of AARP and NRTA in the health care field is to foster and promote efficient delivery to the elderly of the best possible services at the least possible cost, thus making them readily available even for persons living within fixed and limited incomes. AARP and NRTA have advanced and supported introduction of strong cost containment measures, such as negotiated fee schedules and prospective reimbursement, which foster competition in the health care industry, because amici steadfastly maintain that elimination of all anti-competitive barriers is essential if the ultimate goal is to be achieved. To this end, amici have consistently argued before federal and state

legislatures and administrative agencies that the health and medical professions should not be exempt from the antitrust laws and that all existing state or federal antitrust exemptions in the health care field should be abolished.[1]

Instead of reducing the scope of such exemptions, the decision of the Ninth Circuit herein has created what amounts to a *new* exemption for physicians from Section 1 of the Sherman Act. It seeks to justify creation of this new exemption for physicians simply because there already exist anti-competitive characteristics in the health care industry! This is paradoxical at best and dangerous at worst. The absence from the health care field of "ideal competitive conditions"[2] bears no logical relation to a conclusion that physicians' price arrangements in Maricopa and Pima counties are not *per se* contracts or combinations in "restraint of trade".[3]

Fixed and uniform fee-for-service schedules such as those adopted by the physicians in Maricopa and Pima counties,

1. The Health Policy chapter of the AARP-NRTA 1980 Federal and State Legislative Program was introduced into the Congressional Record by Congressman Charles B. Rangel (D-N. Y.), Chairman of the Subcommittee on Health of the House Committee on Ways and Means, on May 19, 1980, 126 CONG. REC. E2471 (1980); in addition, amici have testified and submitted statements to the FTC on April 30, 1980 in respect of "Medical Participation in Control of Certain Open-Panel Medical Prepayment Plans"; to the Senate Finance Committee on April 11, 1980 in respect of "Health Care and the Elderly in the Present Economic Climate"; to the Health Subcommittee of the Senate Finance Committee on March 18, 1980 in respect of The Health Incentive Reform Act of 1980 (S.1968); and to the Health Subcommittee of the House Interstate and Foreign Commerce Committee on February 14, 1978 in respect of the Health Planning and Resources Development Amendments of 1978 (H.R. 10460).

2. *See* Appendix A to the Petition, p. 6.

3. *See* § 1 of the Sherman Act, 15 U.S.C. § 1.

are in diametric opposition to the strong cost containment measures, such as negotiated fee schedules and prospective reimbursement, that amici have advanced in their endeavor to promote competition in the health care field. These measures involve pre-encounter budgeting for patient care and hold the physician accountable for expenditures in excess of the budget, thereby giving health care consumers, more often than not older people, some control over the cost of treatment.

The consequence of the Ninth Circuit's decision will be to encourage, more firmly than ever, that physician groups may with impunity control third-party payor plans. The result of such judicially condoned unfair and anti-competitive trade practices can only be inevitably to reduce and eliminate competition and to aid physicians in achieving target level incomes at the expense of consumers of health care services who are, disproportionately, older Americans.

ARGUMENT

Amici respectfully join in the legal argument advanced by the Petitioner and by the states of Alabama, Alaska, Arkansas, Colorado, Connecticut, Delaware, Florida, Hawaii, Illinois, Indiana, Iowa, Kansas, Louisiana, Maine, Maryland, Michigan, Minnesota, Mississippi, Missouri, Montana, Nebraska, Nevada, New Hampshire, New Jersey, New Mexico, New York, North Carolina, North Dakota, Ohio, Oklahoma, Oregon, Rhode Island, South Dakota, Tennessee, Texas, Utah, Vermont, Washington, West Virginia, Wisconsin, Wyoming, and the Commonwealths of Kentucky and Massachusetts as amici curiae in support of the Petitioner. We respectfully highlight below several points of direct concern to AARP and NRTA.

I.

THE NINTH CIRCUIT'S CREATION OF A SPECIAL ANTITRUST EXEMPTION FOR HORIZONTAL PRICE FIXING AMONG PHYSICIANS THREATENS TO DESTROY ANY CHANCE FOR HEALTH CARE COST CONTAINMENT.

The opinion of the Ninth Circuit upholds an exemption for physicians from established antitrust standards of enforcement, because, it said it was "confronted with an industry widely deviant from a reasonably free competitive model."[4]

In other words, says the Ninth Circuit, because no competition exists now, it is acceptable to permit admittedly anti-competitive practices to continue unchecked. But it is these very anti-competitive practices which Congress sought to stamp out via the Sherman Act. The fact that the health care field may be markedly anti-competitive cannot be used as a crutch to condone and encourage the carving out of an undesirable exemption from the Sherman Act. The Ninth Circuit opinion threatens to eliminate in one fell swoop all recent Congressional and Federal Trade Commission (FTC) action designed to foster competition, which amici have vigorously supported.[5]

Congress, recognizing the anti-competitive features of the health care field, has denominated the strengthening of competition as a national health priority[6] and has established incentives specifically aimed at fostering competition in the health care marketplace. The FTC, similarly concerned with health care cost containment, is working

4. *See* Appendix A to the Petition, p. 6.

5. *See, e.g.*, 42 U.S.C. § 300k-2(a)(17); FTC, *Medical Participation in Control of Certain Open Panel Medical Prepayment Plans*, 45 Fed. Reg. 17019 (1980) (to be codified in 16 C.F.R. ch. 1); *See also* Footnote 1, *supra*.

6. 42 U.S.C. § 300k-2(a)(17).

to lessen physician control of Blue Shield boards responsible for reimbursement policy and fees.[7] Amici have worked hard to promote implementation of these and other responses to the anti-competitive nature of the health care field.

Judge Sneed's opinion below endows the medical profession with a protected status and creates a dangerous precedent in defense of price fixing by ruling that it is the *reasonableness* of the fixed prices that is determinative, as opposed to the *act* of fixing those prices by contract or agreement, even though that act might otherwise be in direct contravention of § 1 of the Sherman Act. This new "rule of reason" would seem to require that with each change in price, the burden falls on the consuming public to institute suit and seek a court determination on the "reasonableness" of the newly established price list. The opinion ignores the fact recognized by Congress, the FTC and this Court that today's so-called fixed but "reasonable" price will undoubtedly be tomorrow's fixed and unreasonable price.[8]

Furthermore, where it is possible to create a competitive environment, as clearly seems feasible in the health care field, it should not be for doctors or courts to substitute their judgment as to the reasonableness of prices for the normal forces of the market. It is, therefore, not in the public interest that a judicial exemption for the medical profession be permitted to stand or that doctors be permitted to fix prices.

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7. FTC, *Medical Participation in Control of Certain Open Panel Medical Prepayment Plans*, 45 Fed. Reg. 17019 (1980) (to be codified in 16 C.F.R. ch. 1).

8. *See* Footnotes 6 and 7, *supra; See also National Society of Professional Engineers* v. *United States*, 435 U.S. 679, 689 (1978); *United States* v. *Socony-Vacuum Oil Co.*, 310 U.S. 150, 212-224 (1940); *United States* v. *Trenton Potteries Co.*, 273 U.S. 392, 397 (1927); *United States* v. *Trans-Missouri Freight Ass'n*, 166 U.S. 290, 340-341 (1897).

II.

OLDER AMERICANS ARE ENTITLED TO PURCHASE AND NEGOTIATE FOR DOCTORS' SERVICES IN AN OPEN, COMPETITIVE MARKETPLACE.

The Sherman Act is a clear enunciation of the consumer's right to negotiate for all goods and services, including physicians' services, at arms-length, in an open, competitive marketplace. This right has been reaffirmed in recent legislation.[9]

The Ninth Circuit's opinion, condoning physicians' price fixing because the prices may be "reasonable", bypasses the relevant statutory inquiry, i.e. has there been price fixing?[10] If there has been price fixing, by definition, competition has indeed been restrained, and consumers of health care, a disproportionate number of whom are older Americans, have thereby been deprived of the competitive market conditions which are desirable to bring them the best health care at the lowest cost.

If the Ninth Circuit's decision is affirmed, it will constitute judicial sanction of the absence of competition in delivery of health care services and will act as a brake on the efforts of amici and others to expand such competition in order to improve the availability and quality of health care for the elderly.

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9. *See, e.g.*, 42 U.S.C. § 300k-2(a)(17).
10. *See* Appendix A to the Petition, pp. 6-7, 31.

CONCLUSION

Amici have a special interest and concern in expanding the limited competitive forces that operate in the health care market. Price fixing arrangements among physicians which can result only in higher health care costs for vulnerable older Americans, and indeed for all consumers of medical services, should not be afforded judicial sanction.

WHEREFORE, amici respectfully request that the Petition for a Writ of Certiorari to the U.S. Court of Appeals for the Ninth Circuit be granted.

Respectfully submitted,

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No. 80-419

IN THE

SUPREME COURT OF THE UNITED STATES

OCTOBER TERM, 1980

STATE OF ARIZONA,

Petitioner,

vs.

MARICOPA COUNTY MEDICAL SOCIETY,
MARICOPA FOUNDATION FOR MEDICAL CARE, and
PIMA FOUNDATION FOR MEDICAL CARE,

Respondents.

ON A PETITION FOR A WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE NINTH CIRCUIT

MOTION OF THE GRAY PANTHERS FOR PERMISSION TO FILE A BRIEF AMICUS CURIAE
and
BRIEF OF THE GRAY PANTHERS AS AMICUS CURIAE

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IN THE

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No. 80-419

STATE OF ARIZONA,

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MARICOPA COUNTY MEDICAL SOCIETY, MARICOPA FOUNDATION FOR MEDICAL CARE, and PIMA FOUNDATION FOR MEDICAL CARE,

Respondents.

ON A PETITION FOR A WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE NINTH CIRCUIT

MOTION OF THE GRAY PANTHERS FOR PERMISSION TO FILE A BRIEF AMICUS CURIAE

The Gray Panthers, through their undersigned counsel, moves pursuant to Rule 36, Rules of the United States Supreme Court, for permission to file a brief amicus curiae on a petition for a writ of certiorari in *State of Arizona v. Maricopa County Medical Society, et al.*, No. 80-419. Grounds for this motion are:

1. On September 16, 1980 the State of Arizona filed its petition for a writ of certiorari to the United States Court of Appeals for the Ninth Circuit. The question

presented is whether an agreement among competing physicians establishing fee schedules for their individual services is a *per se* violation of the Sherman Act.

2. The Gray Panthers is an association of persons who are dedicated to protecting the rights and interests of older persons in the United States. It has 42,000 members in the entire nation.

3. The elderly spend a disproportionate amount of their income on health care. Although the income of people over age 65 is substantially lower than that of younger adults, their declining health makes their expenditures for health services substantially higher than those of younger persons. Accordingly, the upward-spiraling inflation in health care costs in the past decade has had a particularly severe effect on the elderly: the Medicare program is leaving an increasingly large health care bill for the elderly to pay out of their own meager resources. In 1975 the elderly paid out of their pockets $398.88 per capita for health care, which is more than their total per capita expenditures in 1966 before the Medicare program went into effect, and twice as much as their expenditures during each of the first two years of the Medicare program's administration.[1]

4. The State of Arizona brought this action for declaratory and injunctive relief not only on its own behalf, but also on behalf of its resident citizens. More than 307,000 persons 65 years of age or older, including a substantial number of members of the Gray Panthers, reside and purchase doctors' services in Arizona.

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[1] "The Aged and Their Health Expenditures", prepared by staff of the Subcommittee on Health, House Select Committee on Aging, January, 1977.

5. Thus, the Gray Panthers has a legitimate and vital interest in the petition for a writ of certiorari before this Court and respectfully submit that its argument for the granting of that petition should be presented to and considered by this Court.

6. The Gray Panthers has been unable to obtain the consent of all parties involved in *State of Arizona v. Maricopa County Medical Society, et al.*, to the filing of an amicus curiae brief, thus necessitating this motion.

For the foregoing reasons, the Gray Panthers respectfully moves for permission to file a brief amicus curiae in support of the petition for a writ of certiorari in this matter.

Respectfully submitted,

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October 16, 1980

IN THE

SUPREME COURT OF THE UNITED STATES

OCTOBER TERM, 1980

STATE OF ARIZONA,

Petitioner,

vs.

MARICOPA COUNTY MEDICAL SOCIETY,
MARICOPA FOUNDATION FOR MEDICAL CARE, and
PIMA FOUNDATION FOR MEDICAL CARE,

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ON A PETITION FOR A WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE NINTH CIRCU

BRIEF OF AMICUS CURIAE THE GRAY PANTHERS

BRIEF OF AMICUS CURIAE
THE GRAY PANTHERS

INTEREST OF AMICUS CURIAE

The Gray Panthers respectfully submits this brief amicus curiae in support of the State of Arizona's petition for a writ of certiorari to the United States Court of Appeals for the Ninth Circuit pursuant to Rule 36, Rules of the United States Supreme Court.

The Gray Panthers is a group of persons concerned about the interests of the elderly whose members purchase a substantial amount of medical services in Arizona

and other states. Because like most senior citizens, elderly Gray Panthers generally subsist on fixed incomes, because Medicare covers less than half of their health care costs, and because private insurance to supplement Medicare does not pay for the growing difference between physician's actual charges and the Medicare allowances, any agreement affecting the price of medical services has a direct impact on the membership of the Gray Panthers.

Accordingly, the Gray Panthers has a direct and substantial interest in the question of whether an agreement among competing physicians establishing fee schedules for their individual services is a *per se* violation of the Sherman Act.

ARGUMENT

I.
THE NINTH CIRCUIT'S CREATION OF A SPECIAL ANTITRUST EXEMPTION FOR THE HEALTH CARE INDUSTRY IS A SERIOUS MISINTERPREATION OF THE SHERMAN ACT

In the portion of Judge Sneed's opinion endorsed by Judge Kennedy, the anticompetitive characteristics of the health care industry are taken as cause to exempt the health care industry from established standards of antitrust enforcement. This holding turns the Sherman Act on its head.

Congress has recognized the anticompetitive and inflationary characteristics cited in Judge Sneed's opinion,[1] and has attempted to remedy them.[2] But it has never

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[1] *See e.g.*, U.S. Code Cong. & Adm. News, Vol. 4, p. 7878.

[2] *E.g.*, 42 U.S.C. §300k, *et seq.* (national health planning and development); 42 U.S.C. §1395 *et seq.* (Medicare program for the elderly).

exempted the health care industry from the antitrust laws. To the contrary, in its recent amendment of the 1974 National Health Planning and Resource Development Act, Congress expressed its intention that competition should prevail in that industry.[3] Under these circumstances, Judge Sneed's argument that the special characteristics of the medical marketplace make monopolistic arrangements preferable to competition as a means of controlling prices is foreclosed by the will of Congress and the consistent holdings of this Court. *E.g., National Society of Professional Engineers v. United States*, 435 U.S. 679 (1978); *United States v. Socony-Vacuum Oil Co.*, 310 U.S. 150 (1940).

Indeed, this Court and the lower federal courts have applied established antitrust analysis to the medical care industry with the acquiescence of Congress.[4] That the *per se* rule against price-fixing applies to interstate commerce in professional services has been well established.[5] By diverging from this unanimous authority and

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[3] 42 U.S.C. §300e *et seq.* (Supp. 1979).

[4] *American Medical Ass'n v. United States*, 317 U.S. 519 (1943); *Ballard v. Blue Shield*, 543 F.2d 1075 (4th Cir. 1976), *cert. denied*, 430 U.S. 922 (1977); *Feminist Women's Health Center, Inc. v. Mohammad*, 586 F.2d 530 (5th Cir. 1978), *cert. denied*, 444 U.S. 924 (1979); *United States v. Utah Pharmaceutical Ass'n*, 201 F. Supp. 29 (D. Utah), *aff'd*, 371 U.S. 24 (1962); *Veigaga v. National Bd. of Respiratory Therapy*, 1977-1 CCH Trade Cas. ¶61,274 (N.D. Ill. 1977); *Cf., Group Life & Health Ins. Co. v. Royal Drug Co.*, 440 U.S. 205 (1979).

[5] *National Society of Professional Engineers v. United States*, 435 U.S. 679 (1979); *Goldfarb v. Virginia State Bar*, 421 U.S. 773 (1975); *United States v. National Ass'n of Real Estate Bds.*, 339 U.S. 485 (1950); *United States v. Utah Pharmaceutical Ass'n*, 201 F. Supp. 29 (D. Utah), *aff'd*, 371 U.S. 24 (1962); *United States v. Texas State Bd. of Public Accountancy*, 464 F. Supp. 400 (W.D. Tex. 1978), *aff'd*, 592 F.2d 919 (5th Cir.), *cert. denied*, 444 U.S. 925 (1979); *Vandervelde v. Put & Call Brokers & Dealers Ass'n*, 344 F. Supp. 118 (S.D.N.Y. 1972).

creating a judicial exemption for the medical profession, the Ninth Circuit seriously misinterpreted the Sherman Act. It disregarded the clear will of Congress by creating an antitrust exemption for an entire industry on the paradoxical ground that that industry exhibits grossly anticompetitive conditions.

As a result, Judge Sneed's opinion enunciates an unprecedented standard of proof, requiring that those injured by antitrust violations prove that prices would have been lower had the violation not occurred. It defines the key issue as the relative reasonableness of the prices fixed by the challenged agreement.

> In simplified economic terms, the issue is whether the maximum fee arrangement better permits the attainment of the monopolist's goal, *viz.*, the matching of marginal cost to marginal revenue, or in fact obstructs that end. Appendix A, Petition, at 6.

That simply is not "the issue" posed by the Sherman Act.

Under that Act consumers of health care are entitled to purchase and negotiate for doctors' services in an open, competitive marketplace. Whether or not an agreement among competing physicians on fee schedules for their individual services maximizes their monopoly profit it is unreasonable because it deprives consumers of the opportunity to negotiate at arm's length and to purchase medical services in an open, competitive marketplace.[6] That opportunity is protected by the Sherman Act and cannot be abrogated by the judiciary.

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[6] *National Society of Professional Engineers v. United States*, 435 U.S. 679, 689 (1978); *United States v. Socony-Vacuum Oil Co.*, 310 U.S. 150, 212-224 (1940); *United States v. Trenton Potteries Co.*, 273 U.S. 392, 397 (1927); *United States v. Trans-Missouri Freight Ass'n.*, 166 U.S. 290, 340-341 (1897).

II.
THE MEDICARE PROGRAM AND ITS BENEFICIARIES ARE DETRIMENTALLY AFFECTED BY THE PHYSICIANS' FEE SCHEDULES AT ISSUE HEREIN.

Judge Sneed based his opinion on certain assumed "anti-competitive characteristics" of the health care industry that he thought affected the appropriateness of free market price competition in the industry.[7] Although not clearly articulated, these assumptions presumably included the existence of the vast Medicare program, which provides health insurance to the aged. Any assumption that the Medicare program somehow justifies fee setting among physicians is completely wrong. As the Gray Panthers is keenly aware, Medicare reimbursement of physicians' fees, as designed by Congress, depends heavily on competition among physicians, both to keep overall program expenditures down and to provide the elderly with adequate levels of reimbursement of their costs for physicians' services.

The Medicare Act prescribes a system for payment of physicians' fees that assumes the existence of fee competition among physicians. Medicare Part B reimburses for physicians' fees on a "reasonable charge" basis: an amount which is the least of three charges, (1) the actual charge, (2) the "customary charge"[8] or (3) the "prevailing charge".[9] 42 U.S.C. Sec. 1392u(b), 42 C.F.R. §405.507.

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[7] Petition, Appendix A at 4-8.

[8] "Customary Charge" is defined by the Department of Health and Human Services in its regulations as the uniform amount charged by the individual physician in the majority of cases for a particular service. 42 C.F.R. §405.503(a).

[9] "Prevailing Charge" is defined by the Department of Health and Human Services as the lowest "customary charge" which is

[footnote continued]

In 1972, amendments were adopted in an attempt to reduce the growth of Medicare expenditures. Congress limited increases above the 1973 "prevailing charge" determination[10] to the extent justified by economic indexes reflecting changes in operating expenses of physicians and in earnings levels.

The Economic Index added as a limit to the "prevailing charge" generates a figure which most often falls below the physicians' "customary charge." This, together with the approximately 1½ year time lag before increases in actual fees are incorporated into the Medicare schedules results in substantial "reasonable charge" reductions in the payments made by Medicare on behalf of its beneficiaries. In the first quarter of 1977, 70.6% of the Part B claims were reduced.[11] This figure was increased to 74.0% in the second quarter of 1979.[12]

Along with this high percentage of reductions in Medicare claims comes a correspondingly high percentage of doctors now refusing to accept assignment of claims. Under Medicare's Part B program the physician decides whether to accept assignment (a concession Congress made to doctors in the negotiations which led to the pas-

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high enough to include 75% of the "customary charges" made for similar services in the same locality during the calendar year preceding the start of the fiscal year (beginning July 1) in which the claim is submitted for payment. 42 C.F.R. §405.504(a)(2)(ii).

[10]The "prevailing charge" for the fiscal year ending June 30, 1973 is the figure which is high enough to include 75% of the "customary charges" made between January 1, 1972 and December 31, 1972 See 42 U.S.C. §1392u(b), 42 C.F.R. §405.504(a)(3)(i).

[11]DHEW, HCFA, "Part B Reasonable Charge and Denial Activity Report: January-March 1977". (10/5/77)

[12]DHEW, HCFA, "Part B Reasonable Charge and Denial Activity Report: April-June, 1979." (9/28/79)

sage of the original Medicare law.[13] When assignment is accepted, the physician agrees to accept as full payment Medicare's allowed charge. Medicare pays the physician 80% of the allowed charge and the doctor can only bill the patient for the remaining 20%. If assignment is *not* accepted the Medicare beneficiary is responsible for 20% of the allowed charge as well as any amount which exceeds Medicare's reasonable charge determination.

In 1971, on 53.8% of the charges submitted for payment, doctors agreed to accept assignment; whereas, in 1978 that figure was down to 49.6%.[14] Because of this high rate of unassigned claims, nearly 70% of the Medicare beneficiaries had some liability; that is, money owed to the doctor for the difference between the physician's charge and the amount Medicare determined to be a "reasonable charge".[15]

Physician fee schedules such as those used by respondents upset the Medicare reimbursement scheme in several ways. By producing a mass of similar charges they essentially determine an increased prevailing charge for the next charge screen, while variations might have kept it down. This, of course, fuels the upward spiral in Medicare program costs. In turn, this annual increase in physicians' charges, combined with the time lag and economic index lid on Medicare reimbursement levels, produces reimbursement levels to beneficiaries that fall far short of

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[13] Felts, William R., M.D., "The Medicare fee index-everyone loses" – Medical Economics 86 (November 24, 1975).

[14] Ferry, Thomas P., Marian Gornich, Marilyn Newton, Carl Hackerman, "Physicians' Charges Under Medicare: Assignment Rates and Beneficiary Liability" 1 Health Care Financing Review 50 (Winter, 1980)

[15] Id. at 59.

the physicians' fees. As fewer and fewer physicians agree to accept assignment (perhaps to maintain their "fee schedules") elderly beneficiaries are forced to pay more for health care out of their own meager resources. Thus, the fee schedules themselves are the "anticompetitive characteristic" that distorts the economics of the Medicare program.

CONCLUSION

The Ninth Circuit's decision in this case creates conflicting standards of antitrust analysis in the circuit courts.[16] The uncertainty and confusion created by these conflicts may well encourage the establishment and maintenance of fee setting arrangements among health care providers, resulting in increased inflation in health costs. In order to prevent potential economic harm, the Supreme Court should issue a writ of certiorari to the United States Court of Appeals for the Ninth Circuit and resolve the important issues raised in this case.

DATED this 16th day of October, 1980.

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[16] See Petition at 17-18.

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No. 80-419

In the Supreme Court of the United States

OCTOBER TERM, 1980

STATE OF ARIZONA, PETITIONER

v.

MARICOPA COUNTY MEDICAL SOCIETY, ET AL.

ON PETITION FOR A WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE NINTH CIRCUIT

BRIEF FOR THE UNITED STATES AS AMICUS CURIAE

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QUESTION PRESENTED

Whether an agreement among competing physicians setting the maximum prices they will charge insurance companies for services provided to insured patients is illegal per se under Section 1 of the Sherman Act.

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This brief is filed in response to the Court's invitation to the Solicitor General to express the views of the United States.

STATEMENT

1. Respondents Maricopa Medical Foundation for Medical Care and Pima Foundation for Medical Care are associations of doctors that approve and administer health insurance plans underwritten by private insurers (Pet. App. 2-3, 39). Membership in the foundations is open to all physicians licensed in Arizona (*id.* at 3). More than 70% of the practicing physicians in each of Maricopa and Pima counties are members of the respective foundations (CR 106, Exhibit E at 1292; CR 7(a), PF 125).[1] The foundations set the maximum amounts that insurers must pay to physicians who provide services to patients enrolled in insurance plans approved by the foundations (Pet. App. 2-3, 39, 42). Members of the foundations agree to accept the insurance payments as full compensation for their services, *i.e.*, they agree not to seek additional payments from their patients (*id.* at 42-43).[2] Insurers wishing to obtain foundation approval for their plans must agree to pay mem-

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[1] "CR" refers to the clerk's record in the court of appeals.

[2] Persons insured under foundation-approved plans may obtain services from nonmember physicians (Br. in Opp. 6). Such nonmember physicians are paid by insurers for charges up to the foundation maximum, but they need not accept this amount in full satisfaction of their charges and may bill patients for the balance of any fee (*ibid.*).

ber physicians for services to insured patients up to the maximums established by the foundations (Pet. App. 43).[3]

2. In 1978 the State of Arizona brought suit in the United States District Court for the District of Arizona seeking injunctive relief against the two foundations, the Maricopa County Medical Society, and the Pima County Medical Society.[4] The complaint alleged that the maximum price agreements constituted price fixing, in violation of Section 1 of the Sherman Act, 15 U.S.C. 1. Arizona moved for summary judgment on the ground that such agreements are illegal per se. The defendants admitted that the foundations, by vote of their member physicians, set the maximum prices to be paid by insurers for services provided to insured patients (Pet. App. 39; CR 54, ¶ 2). While the defendants argued that the foundation plans were procompetitive because they provided an alternative type of health care coverage and that use of a maximum fee was effective in containing health care costs, they did not assert that either of those objectives required that participating doctors set maximum fees.

The district court denied Arizona's motion for summary judgment on the issue of liability (Pet.

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[3] In addition to setting maximum fees, the foundations perform two other functions in conjunction with approved insurance plans: (1) peer review, *i.e.*, evaluation of the necessity and appropriateness of treatment and hospital services rendered to insured patients, and (2) insurance administration, *i.e.*, serving as agents for underwriters and drawing funds from insurers' accounts to pay doctors' bills (Pet. App. 3). Respondents have not asserted that performance of these functions requires that doctors agree on prices.

[4] The Pima County Medical Society was later dismissed under a consent order (Pet. App. 2 n.2).

App. 48). Although it noted that "[p]rice fixing has for some time been viewed as per se unlawful" (Pet. App. 43), the court refused to apply a per se rule to the conduct at issue for two reasons. First, it perceived "a recent antitrust trend [that] appears to be emerging where the Rule of Reason is the preferred method of determining whether a particular practice is in violation of the antitrust law" (*id.* at 43-44). Second, it considered the per se rule inapplicable because members of a profession were involved in the allegedly illegal conduct (*id.* at 45-47). The district court nonetheless certified to the court of appeals the question whether the rule of reason should be used in analyzing the foundations' price fixing activities (*id.* at 50-51).

On appeal, the defendants argued that a rule of reason analysis was required because the "antitrust laws were not intended to straightjacket imaginative experimentation in fields, such as the professions, not traditionally subject to antitrust scrutiny" (Brief of Defendant-Appellee Maricopa Foundation for Medical Care at 36). They also sought (*id.* at 38-39) to justify the rule of reason approach under the Ninth Circuit's decision in *Catalano, Inc.* v. *Target Sales, Inc.*, 605 F.2d 1097 (1979), rev'd and remanded, 446 U.S. 643 (1980). The defendants further argued that the challenged price agreements would not necessarily affect the fees charged to patients, and they asserted that there was no evidence of any coercion to force adherence in patient billing to maximum reimbursement levels. Finally, while the defendants cited this Court's decision in *Broadcast Music, Inc.* v. *Columbia Broadcasting System, Inc.*, 441 U.S. 1 (1979), they did not contend that price agreements among competing doctors are necessary to achieve any procompetitive purpose of the foundations.

The court of appeals affirmed the district court's decision by a divided vote (Pet. App. 1-32). The court recognized that the agreements at issue in this case are agreements among physicians to set maximum fees to be charged to insurers (*id.* at 2). It also recognized that maximum price fixing in a vertical context would be illegal per se under this Court's decisions (*id.* at 7 n.4). Since the present agreements were among direct competitors, however, the court of appeals declined to apply this Court's decisions condemning maximum price agreements. The court of appeals also declined to classify the conduct at issue as illegal per se because of the "professional" nature of the services provided by the defendants (*id.* at 5-6), and because "a restraint may serve the public, the transcendent end of all professions, even though its presence in a purely commercial setting would violate the antitrust law" (*id.* at 12). Finally, the court stated that the "record reveals nothing about the actual competitive effects of the challenged arrangement" (*id.* at 5).

Judge Larson dissented. He concluded that the agreements in question in this case are the type of "naked price restraint" previously held by this Court to be per se illegal. He observed that nothing in the nature of the medical profession or the health care industry warrants an exception from per se rules for price fixing (Pet. App. 19-27). Judge Larson also concluded that "[e]ven if this were the first judicial examination of this form of restraint, its anticompetitive vices are egregious and its procompetitive features nonexistent, so that this Court could declare it to be within the per se rules" (*id.* at 27).[5]

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[5] Judge Larson added that "even if the rule of reason is the correct standard * * * a detailed economic analysis of the in-

ARGUMENT

1. For the second time in a year, the Ninth Circuit has seriously misconstrued the per se doctrine.[6] Its holding conflicts both with decisions of this Court and with sound economic analysis. It should be reversed.

a. This Court long ago established that an agreement among competitors to fix prices is a per se violation of Section 1 of the Sherman Act. *United States* v. *Trenton Potteries Co.*, 273 U.S. 392, 397-399 (1927). As the Court has emphasized: "Under the Sherman Act a combination formed for the purpose and with the effect of raising, depressing, fixing, pegging, or stabilizing * * * price * * * is illegal *per se*." *United States* v. *Socony-Vacuum Oil Co.*, 310 U.S. 150, 223 (1940). The Court consistently has reaffirmed that an "agreement that 'interfere[s] with the setting of price by free market forces' is illegal on its face." *National Society of Professional Engineers* v. *United States*, 435 U.S. 679, 692 (1978), quoting *United States* v. *Container Corp.*, 393 U.S. 333, 337 (1969). Only last year, this Court, in summarily reversing the court of appeals, stressed that a horizontal agreement to fix prices is "the archetypal example" of conduct unlawful per se under Section 1 of the Sherman Act. *Catalano, Inc.* v. *Target Sales, Inc.*, 446 U.S. 643, 647 (1980). In this

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dustry is not necessary. This agreement to fix fees is so plainly anticompetitive that it is an unreasonable restraint of trade on its face" (Pet. App. 31-32).

[6] In *Catalano, Inc.* v. *Target Sales, Inc.*, 446 U.S. 643 (1980), this Court summarily reversed a decision of the Ninth Circuit which had held that an agreement among competitors to eliminate free trade credit did not constitute price fixing and consequently was not per se illegal.

case, the district court and court of appeals found that the defendants are competitors who have made agreements with the purpose and effect of setting the price of their services (Pet. App. 2, 39). Thus, their agreements are illegal per se.[7]

b. The court of appeals thought that the agreements at issue here should not be illegal per se because they set maximum rather than minimum prices (Pet. App. 6-9). But this Court never has limited the per se rule to agreements that fix minimum prices. Forty years ago, the Court made it clear that an agreement "for the purpose and with the effect of * * * depressing * * * price * * * is illegal

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[7] Respondents contend that the foundations' use of conversion factors and relative value schedules to arrive at a fixed level of compensation under approved insurance plans is not price fixing because "[a]ll physicians are free to bill as they like" (Br. in Opp. 6). But freedom to "bill" for an amount one has agreed not to collect has no economic significance. Moreover, a fee schedule serves readily as a list of suggested prices for all medical services; such a list, adopted by direct competitors, is a restraint of trade even if it is not binding. *Nationwide Trailer Rental System, Inc.* v. *United States*, 156 F. Supp. 800, 805 (D. Kan.), aff'd, 355 U.S. 10 (1957); *Plymouth Dealers' Ass'n* v. *United States*, 279 F.2d 128, 130, 134 (9th Cir. 1960). Finally, we note that the parties to any price fixing agreement are free not to adhere to it, since such agreements are legally unenforceable violations of the Sherman Act. Respondents also argue that their conduct is not price fixing because only foundation member physicians are obligated to accept the agreed-upon compensation from the insurer as full payment for their services (Br. in Opp. 6). But, even if the agreements at issue affected only payments made by foundation-approved insurers to member physicians, the agreements would still be illegal per se. Price fixing agreements are illegal even if they "may not be aimed at complete elimination of price competition." *United States* v. *Socony-Vacuum Oil Co., supra*, 310 U.S. at 225 n.59.

per se." *United States* v. *Socony-Vacuum Oil Co.*, *supra*, 310 U.S. at 223. And in *Kiefer-Stewart Co.* v. *Joseph E. Seagram & Sons, Inc.*, 340 U.S. 211, 213 (1951), the Court held that "agreement[s] among competitors to fix maximum resale prices of their products * * * no less than those to fix minimum prices * * * [are] * * * illegal *per se*." See also *Albrecht* v. *Herald Co.*, 390 U.S. 145, 152-154 (1968).

The court of appeals recognized that a vertical agreement to fix a maximum price is illegal per se, but believed that a horizontal agreement should be treated differently (Pet. App. 7 n.4). In *Kiefer-Stewart*, however, the agreement at issue was horizontal as well as vertical. It was to the maximum prices fixed by horizontal competitors—Seagram and Calvert—that the Court spoke in the passage quoted above. Moreover, in terms of economic analysis, it is illogical to impose a stricter rule for vertical maximum price-fixing agreements than for similar horizontal agreements among direct competitors. If there were to be any distinction between vertical and horizontal maximum price fixing, there is a stronger case for per se treatment in the horizontal context. Vertical restraints sometimes have a potential for procompetitive effects which is absent in similar horizontal agreements (*Continental T.V., Inc* v. *GTE Sylvania, Inc.*, 433 U.S. 36, 51-52, 56-59 & n.28 (1977)), and more detailed analysis may be necessary to determine whether vertical restraints should be held unlawful.

Compelling economic reasons support this Court's holdings that agreements to fix maximum prices are illegal per se. First, the maximum price fixed by agreement may operate as a floor as well as a ceiling. See *Albrecht* v. *Herald Co.*, *supra*, 390 U.S. at

153 ("if the actual price charged under a maximum price scheme is nearly always the fixed maximum price, * * * the scheme tends to acquire all the attributes of an arrangement fixing minimum prices"). That danger is clearly present in this case. Doctors have no financial incentive to charge insured patients less than the maximum fee because insurers, in order to obtain foundation approval, previously have agreed to pay any fee up to that maximum. Moreover, insured patients have no direct financial incentive to select a doctor who charges less. The doctor's charge is paid by the insurer, and an individual patient's insurance premiums do not vary on the basis of the fees charged by a particular doctor.

Second, a collective agreement on pricing aggregates sellers' power in a way that is injurious to buyers. Even if it might have the short-run effect of containing cost increases, such an aggregation of the market power of doctors as sellers of medical services can do nothing to alleviate the more general problem of subnormal competition in the health care industry. This Court repeatedly has rejected the argument, apparently accepted by the court of appeals, that price fixing may be lawful if it holds the cost of goods or services at a reasonable level (Pet. App. 6). Because price fixing repeatedly has been found to be anticompetitive, "[i]t is no excuse that the prices fixed are themselves reasonable." *Catalano, Inc.* v. *Target Sales, Inc.*, *supra*, 446 U.S. at 647; *United States* v. *Trenton Potteries Co.*, *supra*, 273 U.S. at 397-398; *United States* v. *Trans-Missouri Freight Ass'n*, 166 U.S. 290, 340-341 (1897); *United States* v. *Socony-Vacuum Oil Co.*, *supra*.

Indeed, the agreements at issue here serve to inhibit unilateral actions by insurers to restrain costs

through prescription of their own maximum payments to physicians. See generally *Group Life & Health Insurance Co.* v. *Royal Drug Co.*, 440 U.S. 205, 209-210 & n.5 (1979). When competing physicians do not set prices, insurers have an economic incentive to negotiate fee schedules that will minimize costs for medical services rendered to their subscribers, for they maximize their own profits by doing so. And when there is competition or potential competition among insurers to minimize medical payments, the benefits of their actions accrue to the public. Insurers who succeed in limiting their costs are able to offer lower premiums than insurers who do not, and those who offer lower premiums for similar benefits have a competitive advantage in attracting and retaining subscribers.

When all insurers are faced with a single price schedule fixed by doctors through foundations, however, competition among insurers has a much more limited potential for minimizing consumer costs. Efforts by doctors to fix insurer costs deprive insurers and physicians alike of their power to make independent decisions that are the hallmark of a competitive market system. See *Kiefer-Stewart Co.* v. *Joseph E. Seagram & Sons, Inc.*, *supra*, 340 U.S. at 213; L. Sullivan, *Antitrust* § 78 at 210-212 (1977).

Third, a maximum price agreement may effectively impede new entry. L. Sullivan, *supra*, § 78 at 211. In contrast to individual insurers, who have a financial incentive to set doctors' fees at as low a level as possible in order to reduce premium costs and thereby maximize their own profits, competing doctors have a financial incentive to limit their fees by agreement only if that would impede new entry. While the agreements at issue in this case might not impede entry into the medical profession as such, they could

be used as devices to impede entry by competing systems of prepaid health care, such as health maintenance organizations ("HMOs"),[8] or to forestall the development of other types of health care systems deemed undesirable by physicians operating under currently prevailing methods.

c. This court's decision in *Broadcast Music Inc.* v. *Columbia Broadcasting System, Inc.*, 441 U.S. 1, 19-23 (1979), relied on by respondents, does not require a rule of reason analysis in this case. Neither the district court nor the court of appeals, after extensive briefing, identified any ground for inferring that maximum price fixing by competing physicians serves a procompetitive purpose.[9] And possible beneficial

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[8] See note 9 *infra*; see also Havighurst, *Health Maintenance Organizations and the Health Planner*, 1978 Utah L. Rev. 123, 129-130, 132-134.

[9] The agreements at issue in this case differ fundamentally from the kinds of agreements that facilitate the operation of health maintenance organizations (HMOs). The member physicians of the defendant foundations practice as separate economic entities who have not integrated their medical practices, entered into any risk-sharing arrangements, or taken other steps that might warrant joint venture analysis under the rule of reason. By contrast, the Health Maintenance Organization Act of 1973, 42 U.S.C. 300e *et seq.*, provides that, in a health maintenance organization, a group of physicians and other health professionals may provide coordinated and integrated comprehensive medical services to subscribers for a periodic fee, and that physicians and others in the HMO must share income (from subscriber fees) and expenses according to predetermined employment or partnership agreements under which the physicians are at risk for any adverse financial results of the HMO. Thus, agreements about the fees to be charged subscribers and the salaries or partnership shares to be paid to physicians and others who provide services through an HMO, like similar agreements among

effects that are not procompetitive are not cognizable under the rule of reason. *National Society of Professional Engineers* v. *United States*, 435 U.S. 679, 691-692, 693-694 (1978).

The inability of respondents and the lower courts to identify any procompetitive effect stemming from maximum price fixing is not surprising. Medical cost containment and the offering of a competitively priced health insurance plan simply do not require price fixing agreements among competitors. Insurers can, and regularly do, establish their own maximum payments to physicians who provide medical services to insured patients. See generally *Group Life & Health Insurance Co.* v. *Royal Drug Co.*, 440 U.S. 205, 209-210 & n.5 (1979); see also the brief amicus curiae filed by the United States in the *Royal Drug Co.* case (77-952 Br. 10-13). Indeed, the Maricopa Foundation itself has a contract with the State of Arizona to administer the Comprehensive Medical Dental Program for Foster Children, a program in which maximum payments to physicians are set by a state agency —not by competing doctors (Br. in Opp. 7).

Nor do the other functions performed by the foundation require price fixing agreements. The foundations review the medical necessity and appropriateness of treatment given to insured patients and, for some groups, the necessity and appropriateness of hospital utilization (Pet. App. 3; Br. in Opp. 4). For some insured groups the foundations also serve as agents for underwriters to facilitate claims payments to doctors (Pet. App. 3; Br. in Opp. 4).

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individuals who form a partnership or corporation, may be essential to render the service provided by the HMO. *United States* v. *Addyston Pipe & Steel Co.*, 85 F. 271, 281-282 (6th Cir. 1898) (Taft, J.).

There is no suggestion, even by respondents, that performance of either of these functions requires agreements on price.

Thus, whatever may be the proper approach to other agreements in the health care field, respondents have failed to advance any acceptable ground for examining their price fixing agreements under the rule of reason or for undertaking a more thorough review to determine whether the rule of reason should be applied. They have offered no explanation why their price fixing activities are essential to the competitive functioning of the health care market, and have offered no reason for departing from this Court's decisions in *Kiefer-Stewart* and *Socony-Vacuum*.

d. Deficiencies in competition in the health care industry perceived by the court of appeals (Pet. App. 6) do not justify private restraints that eliminate or undermine such competition as there is. If market forces do not result in a socially acceptable level of price or supply of particular goods or services, state and federal legislatures may regulate the competitive process. See, *e.g.*, The National Health Planning and Resources Development Act of 1974, 42 U.S.C. (Supp. III) 300k-1, 300m-2, 300m-6 and 300n-1(b) (certificate of need program requiring state agency approval of new competitive entry by health care providers). But it is solely the province of the legislatures, not private groups, to advance social values by superseding price competition. *National Society of Professional Engineers* v. *United States*, *supra*, 435 U.S. at 695-696; see also *Standard Oil Co.* v. *FTC*, 340 U.S. 231, 248 (1951); *Fashion Originators' Guild* v. *FTC*, 312 U.S. 457, 467-468 (1941).

2. The court of appeals' decision also conflicts with this Court's decisions holding that an agreement

among competitors fixing prices is not exempt from per se treatment merely because the parties to the agreement are professionals. *Goldfarb* v. *Virginia State Bar*, 421 U.S. 773, 788 (1975); *National Society of Professional Engineers* v. *United States*, 435 U.S. 679, 696 (1978). While the decisions in *Goldfarb* and *Professional Engineers* do not resolve the legality of all types of collective conduct by professionals, they clearly recognize that price fixing by lawyers and engineers is per se unlawful. The agreements at issue in this case have no purpose other than fixing prices. And nothing about the medical profession distinguishes it from the legal and engineering professions in any respect relevant to the applicability of the per se rule against price fixing.

3. The court of appeals' decision merits correction now. By confusing the law applicable to price fixing, the decision saddles trial courts with the very kind of protracted factual inquiry that this Court rejected when it adopted the per se rule in *United States* v. *Trenton Potteries Co.*, *supra*, 273 U.S. at 398. Moreover, the adverse effects go beyond burdening the courts. The court of appeals' decision deprives health professionals, insurers, and enforcement authorities of the clear standard that the per se rule is intended to supply. *Ibid.* It impedes the efforts of the Department of Justice and the Federal Trade Commission to stop price fixing by professionals[10] and to insure that prepaid medical and legal pro-

[10] See, *e.g.*, *National Society of Professional Engineers* v. *United States*, *supra*; *United States* v. *Geneva County Bar Ass'n*, Civ. No. 80-113-S (M.D. Ala.) (amended complaint filed Dec. 9, 1980); *United States* v. *McAliley*, Civ. No. 80-111-S (M.D. Ala.) (complaint filed Dec. 9, 1980); *United States* v. *Cassady, Fuller & Marsh*, Civ. No. 80-110-S (M.D. Ala.) (complaint filed Dec. 9, 1980).

grams are structured so that they neither authorize nor facilitate such price fixing. The adverse effect of the decision of the court of appeals on the law of price fixing is magnified by the fact that it occurs in the vast and growing health care industry and the likelihood that it will be applied to economically significant markets involving other professional services as well.[11]

CONCLUSION

The petition for a writ of certiorari should be granted.[12]

Respectfully submitted.

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[11] The health services industry employs more than five million persons (U.S. Department of Labor, Bureau of Labor Statistics, *Employment and Earnings, September 1980* at 57). Annual national health care expenditures now total more than $200 billion (*Projections of National Health Expenditures, Health Care Financing Review* 1, 11 (Winter 1980); see also S. Rep. No. 93-129, 93d Cong., 1st Sess. 8 (1973)).

[12] The Court may wish to consider summary reversal. See *Catalano, Inc.* v. *Target Sales, Inc., supra.*

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OCTOBER TERM, 1980

STATE OF ARIZONA,
Petitioner,

vs.

MARICOPA COUNTY MEDICAL SOCIETY,
MARICOPA FOUNDATION FOR MEDICAL CARE, and
PIMA FOUNDATION FOR MEDICAL CARE,
Respondents.

ON WRIT OF CERTIORARI TO THE
UNITED STATES COURT OF APPEALS
FOR THE NINTH CIRCUIT

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QUESTION PRESENTED

Is an agreement among competing physicians establishing fee schedules for their individual services a *per se* violation of section 1 of the Sherman Act?

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Clerk's Record ..... C.R.

Joint Appendix ..... J.A.

Joint Brief in Opposition ..... Br. in Opp.

Petition for a Writ of Certiorari ..... Pet.

Reply Memorandum for Petitioner ..... Reply

No. 80-419

IN THE

Supreme Court of the United States

OCTOBER TERM, 1980

STATE OF ARIZONA,
Petitioner,

vs.

MARICOPA COUNTY MEDICAL SOCIETY,
MARICOPA FOUNDATION FOR MEDICAL CARE, and
PIMA FOUNDATION FOR MEDICAL CARE,
Respondents.

ON WRIT OF CERTIORARI TO THE
UNITED STATES COURT OF APPEALS
FOR THE NINTH CIRCUIT

BRIEF FOR PETITIONER

OPINIONS BELOW

The June 5, 1979, memorandum and order of the District Court denying plaintiff's motion for partial summary judgment on the issue of liability under the *per se* standard (Pet. App. D), its August 6, 1979, order denying plaintiff's motions for reconsideration of the June 5 order and for partial summary judgment under the Rule of Reason (Pet. App. E), and its August 8, 1979, order certifying the June 5 decision for interlocutory appeal (Pet. App. F) have not been officially reported. The opinion of Judge Sneed, the concurring opinion of Judge Kennedy and the dissenting opinion of Judge Larson filed March 20, 1980 (Pet.

App. A), as amended on April 28, 1980, (Pet. App. B), and the Court of Appeals' order of June 18, 1980, denying the petition for rehearing (Pet. App. H), are reported at 643 F.2d 553.

JURISDICTION

The opinion of the United States Court of Appeals for the Ninth Circuit was filed on March 20, 1980, and modified on April 28, 1980. The State of Arizona timely filed a petition for rehearing and rehearing en banc which was denied on June 18, 1980. The petition for a writ of certiorari was filed September 16, 1980, and was granted March 9, 1981. 450 U.S. _____. The jurisdiction of this Court is invoked under 28 U.S.C. § 1254(1).

STATUTORY PROVISION INVOLVED

Section 1 of the Sherman Act, 15 U.S.C. § 1, provides in pertinent part:

> Every contract, combination in the form of trust or otherwise, or conspiracy, in restraint of trade or commerce among the several States or with foreign nations, is hereby declared to be illegal.

STATEMENT

The Foundations Have Established and Maintained Uniform Fee Schedules for Doctors' Services

The Maricopa and Pima Foundations for Medical Care are associations of doctors in Arizona's two most populous counties[1] which were created to promote "fee-for-service

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[1] Pet. App. D at 38-39; J.A. 123 ¶ 1; 144 ¶ 1; 188 ¶ 428. The Maricopa Foundation's parent corporation the Maricopa County Medical Society is also a named defendant. The Maricopa Society formed the Maricopa Foundation in 1969 and the two organizations share the same personnel and offices and the Society appoints the members of the Foundation's governing board. J.A. 189-90 ¶¶ 3, 5; 210 ¶ 90; 272 ¶¶ 2-3, 5; 273 ¶¶ 314-15; *see also* C.R. 7(b), Exhibit MF-119

[1] The Pima Foundation's parent the Pima County Medical Society was named as a defendant but it agreed to a consent judgment and is no longer a party. 643 F.2d, at 554 n.2.

medicine."[2] With approximately 1750 active members, the Maricopa Foundation has consistently maintained its membership levels at over 70 percent of the physicians in Maricopa County. (J.A. 407). The Pima Foundation has approximately 400 members (J.A. 74 ¶ 4) and in November 1975 its membership included "[m]ore than 80 percent of the privately practicing physicians in the Pima County area." (C.R. 7(a), Exhibit PF-125).

[2] J.A. 171 ¶ 317; 210 ¶ 91. "Fee-for-service medicine" refers to the sale of doctors' services for a fee based upon the services rendered in contrast to work performed for a salary or for capitation payments. *See generally* Goldberg and Greenberg, *The Effect of Physician-Controlled Health Insurance: U.S. v. Oregon State Medical Society*, 2 J. Health Pol., Pol'y & L. 48, 51 (1977); Havighurst, *Professional Restraints on Innovation in Health Care Financing*, 1978 Duke L.J. 303, 306; Kallstrom, *Health Care Cost Control by Third Party Payors: Fee Schedules and the Sherman Act*, 1978 Duke L. J. 645, 647.

The foundations' by-laws grant their members the power "to vote on the adoption of ... uniform fee schedules."[3] To arrive at their fee schedules, the foundations first consult with the different medical specialty associations to determine the prices charged by their members (J.A. 163 ¶ 44; 200 ¶ 44; *see, e.g.*, Reply Apps. A and B) and then use this information to formulate the fee schedules sent to foundation members for formal approval. (J.A. 164 ¶ 54; 202 ¶ 54). These fee schedules have two components, the "relative value" and the "conversion factor." The "relative value" is a numerical weight assigned for each type of service or procedure performed by a physician. Thus, a routine, follow-up office visit might have a relative value of 1.0, while a home visit might have a relative value of 7.0. The "conversion factor" is the dollar amount used to determine fees for a particular medical specialty. Thus, in 1978 the conversion factor for surgery was $10.50, while that for anesthesiology was $13.25. (J.A. 268 ¶ 304). The actual price

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[3] J.A. 155 ¶ 37 (collecting citations); *see also id.* 134 ¶ 37; 162 ¶ 34; 198 ¶ 4; *Arizona v. Maricopa Medical Soc'y*, 643 F.2d, at 555.

Conveniently choosing to ignore the explicit language in their own by-laws and in extensive correspondence, respondents attmept to argue that "[t]his action does *not* involve an agreement by doctors on prices to charge their patients ...." Br. in Opp. at 1. The distinction respondents seem to be making is that they have agreed upon the "level of reimbursement," *e.g.*, *id.* at 3, or the amount they will be paid by their patients and third-party payors rather than upon the prices they charge those patients and third-parties. This is a distinction without a difference.

If anything, the distinction respondents seek to draw is suggestive of greater price uniformity. In *United States v. National Association of Real Estate Boards*, 339 U.S. 485 (1950), the prescribed rates from the fee schedule were used in the great majority of transactions, although in exceptional circumstances a lower charge was made. These occasional deviations did not lessen the illegality of the agreed-upon fee schedule. *See also International Salt Co. v. United States*, 332 U.S. 392, 398 (1947) (that violation had not occurred in all transactions did not preclude summary judgment on liability). Where, as here, the agreement is on the level of reimbursement rather than the quoted price, any incentive to deviate from the agreed-upon price is eliminated even in "exceptional circumstances."

for a particular procedure is determined by multiplying the relative value for that procedure by the applicable conversion factor. (*See, e.g.*, J.A. 35-36).

The ostensible purpose of the foundation fee schedules is to establish "the maximum level of reimbursement" that a foundation member may receive for services performed under a foundation-endorsed pre-paid health plan.[4] The foundations establish certain minimum standards which must be met if a health plan is to receive their formal en-

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[4] Pre-paid health plans fall into two general categories. One is based upon indemnification under which a third-party such as an insurer or an employer pays the health care provider all or part of the price for medical services actually performed. The economic risk of this type of health plan is borne by the third-party and no economic integration among the different providers is required. The other category is defined by capitation payments in which subscribers to the plan pay the providers a fixed periodic fee in return for which the providers agree to furnish any future medical services that might be required. In this category, the economic risk is borne by the providers and some degree of economic integration among the providers is required. The foundation-endorsed health plans all fall into the first category while independent practice associations and health maintenance organizations authorized under the Health Maintenance Organization Act of 1973, 42 U.S.C. § 300e *et seq.*, are in the second category. *See* Kissam, *Health Maintenance Organizations and the Role of Antitrust Law*, 1978 Duke L.J. 487, 490. It is generally acknowledged that the second category of pre-paid health plans provides significantly greater incentives for cost-containment than the first. *See, e.g.*, Kissam, *supra*, at 490.

While precise market share data are not available, a 1974 analysis by the Maricopa Foundation placed it with approximately four times as many subscribers as health maintenance organizations and approximately three times the number of subscribers as all other indemnification health plans combined. (C.R. 7(b), Exhibit MF-90 at 2). These ratios would indicate that the Maricopa Foundation had approximately 63 percent of the pre-paid health care market compared to 16 percent for health maintenance organizations and 21 percent for other indemnification plans.

dorsement.[5] If a third-party[6] payor agrees to abide by the fee schedule and other minimum standards established by the foundations, the foundations will formally endorse its health plan. In turn, the foundations' members agree to accept as full payment for any medical services provided pursuant to foundations plans their "usual and customary fees . . . but not to exceed the maximum level of reimbursement established by the foundation." Br. in Opp. at 4.

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[5] *See, e.g.*, C.R. 7(b), Exhibit MF-64 (Maricopa Foundation for Medical Care, Minimum Standards for Foundation-Endorsed Group Insurance Programs, January 1, 1976).

The minimum standards promulgated by the foundations have other anticompetitive and inflationary provisions in addition to the obvious one involved with the agreed-upon fee schedules. The foundations' minimum standards require relatively low deductible amounts to be paid by patients (*e.g., id.*, at 4 ¶ 10, 12 ¶ 38) which encourages overutilization of medical services with a concomitant increase in insurance premiums and physicians' incomes. *Cf.* Havighurst, *Professional Restraints on Innovation in Health Care Financing*, 1978 Duke L.J. 645, 647. Similarly, the foundations' minimum standards provide that payments may only be made to certain categories of health care providers (*see, e.g.*, C.R. 7(b), Exhibit MF-64, at 3 ¶ 7) which of course constitutes a boycott of the other categories of licensed health care providers who are not eligible to receive payment. *E.g., Virginia Academy of Clinical Psychologists v. Blue Shield*, 624 F.2d 476 (4th Cir. 1980). To the same effect, the foundations' minimum standards require that hospitals only be paid for 80 percent of their charges (C.R. 7(b), Exhibit MF-64, at 10 ¶ 2), while the physician members of the foundations receive 100 percent of their charges.

[6] Respondents and even the United States in its amicus brief refer repeatedly to payments by health insurers and, while this is a convenient shorthand, it is somewhat lacking in precision. Under foundation-endorsed health plans, payments might be made either by health insurance companies or by major employers such as Motorola, Inc. or the State of Arizona which are sufficiently large that they do not need an intermediate insurance company to underwrite the actuarial risk. To the same effect, the foundation-endorsed health plans have deductible limits which must be met by the patient before any third-party reimbursements is made and payments against the deductible limits are made directly by the patients and not by any third-party.

Although the foundations' fee schedules supposedly set only maximum prices and purportedly are limited to foundation-endorsed health plans, they actually have had an inflationary impact which belies their characterization as "maximum" fee schedules and which reaches much further than formally-endorsed plans. A 1974 analysis by the Maricopa Foundation, for example, boasted that its fee schedule had increased between 30 to 33 percent in just five years. (C.R. 7(b), Exhibit MF-90). Moreover, the foundations' fee schedules have been set at levels higher than both the average and median fees of Arizona doctors as determined by the foundations' own price surveys.[7] And, once the fee schedules are established through the elaborate process of price surveys and formal voting, foundation members revise their prices so that some 85 to 95 percent charge prices at or above those established by the fee schedules. *Arizona v. Maricopa County Medical Society*, 643 F.2d 553, 555 (1980). Indeed, defendants readily admitted that member

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[7] *Compare, e.g.*, J.A. 247-48 ¶¶ 225-27, 230 ("1975 fee survey indicated that the average conversion factor . . charged by physicians within the State of Arizona for medicine was $10.20; for surgery was $9.28 and for anesthesia was $12.30"), *with* J.A. 249 ¶ 233 (foundation fee schedule approved following 1975 fee survey included conversion factors of $11.00 for medicine, $9.50 for surgery, and $12.00 for anesthiology). *See also* pages 11 to 12, *infra*.

Although respondents claim that they "never set a maximum reimbursement level in excess of . . . the . . . prevailing average or median fees charged by physicians in the community," Br. in Opp. at 4, this argument is demonstrably incorrect and is refuted by facts respondents themselves admitted to be true pursuant to Rule 36, Federal Rules of Civil Procedure. Under Rule 36(b), "Any matter admitted under this rule is conclusively established unless the court on motion permits withdrawal or amendment of the admission" and since respondents have made no such motion they cannot now escape the consequences of their admission.

doctors required concerted price increases as a condition of continued membership in the foundations.*

Agreed-Upon Increases in "Conversion Factors" Result in Across-the-Board Increases in Doctors' Prices

The conversion factors apply to all medical procedures and an increase in the conversion factors therefore results in an across-the-board increase in doctors' prices. The steps leading to the December 1, 1977, revision of the Maricopa Foundation fee schedule illustrate how this process operated.

As of January 1, 1976, the Maricopa Foundation had an approved conversion factor of $9.50 for surgery with different conversion factors for the other medical specialties. (J.A. 249 ¶¶ 233-34). At its March 21, 1977, meeting the Maricopa Foundation's Board of Trustees "directed that speciality societies be consulted in April and May of 1977 so that by June of 1977 the Board will have material available to determine new conversion factors." (J.A. 260 ¶ 279; *see also* C.R. 7(b), Exhibit MF-51). On April 14, 1977, the foundation sent a series of letters to the various surgical and other specialty societies asking that their members be

* In both the district court and the court of appeals, respondents claimed that doctors were threatening to leave the foundations if they could not increase their agreed-upon fees, an open admission that fees for individual services were controlled by the collective membership and could not be adjusted individually by doctor or insurer. See the dissenting opinion of Judge Larson, 643 F.2d, at 567; Appellees' Brief in the Court of Appeals at 24.

polled about desired changes in conversion factors.[9] While a few of the specialty societies declined to participate in this pricing poll because they viewed it to be unlawful price-fixing (*see, e.g.*, C.R. 7(b), Exhibits MF-20 to -22), most responded with the requested information regarding desired price levels. (*E.g.*, J.A. 264-66 ¶¶ 291-96; *see, e.g.*, Reply App. C).

The surgical specialties were unanimous in rejecting the foundations' current conversion factor of $9.50 and all of these societies recommended that the conversion factor be increased. Dr. Richard Zonis, president of the Arizona Society of Otolarynology, for example, had forwarded copies of the April 14 inquiry to members of the society, compiled the responses he had received, and forwarded them to the foundation. (C.R. 7(b), Exhibits MF-13 to -19). Although five of the six responses received by Dr. Zonis indicated they would be satisfied with an increase in the surgical conversion factor to only $10.00 (*id.*, Exhibits MF-14 to -16, -18 to -19) and the other indicated that a five to ten percent increase would be sufficient (*id.*, Exhibit MF-17), Dr. Zonis' note forwarding the results of his poll said, "All of our members feel that an increase is in order, the range being from 10.0 - 11.0 or an increase of 10%, which amounts to about the same thing. I personally favor a 10% increase to

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[9] J.A. 261 ¶¶ 281-82; *see, e.g.*, Reply App. A

These requests for pricing information and desired increases were sent to the Arizona Chapter of the American College of Chest Physicians, Arizona Opthalmological Society, Arizona Society of Allergists, Arizona Society of Anesthesiologists, Arizona Society of Internal Medicine, Arizona Society of Otolaryngology, Arizona Thoracic Society, Maricopa County Pediatric Society, Maricopa County Plastic Surgeons Society, Phoenix Dermatological Society, Phoenix Obstetrical and Gynecological Society, Phoenix Orthopedic Association, Phoenix Radiology Society, Phoenix Society of Gastroenterology, Phoenix Surgical Society and Phoenix Urological Society. C.R. 7(b), Exhibits MF-29 to -46.

The requests sent to each of these specialty societies was identical and the responses from each were in the same vein. In the interest of brevity, however, only the responses from the surgical specialities are discussed in the text.

10.5." (*Id.*, Exhibit MF-13). To the same effect was a survey by the Phoenix Obstetrical and Gynecological Society. Dr. Frank Loffer, secretary-treasurer of that society, wrote: "Your letter of April 14, 1977, ... was discussed by the Executive Committee of the Phoenix Obstetrical and Gynecological Society. It was their feeling that the conversion factor for surgery should be increased to $10.50." (C.R. 7(b), Exhibit MF-8). Similarly, the response of the Maricopa County Plastic Surgeons Society said, "[W]e discussed [your letter] at our recent meeting of the Maricopa Plastic Surgeons. It was the feeling of the membership that the surgical rate should be [$10.00] ...." (C.R. 7(b), Exhibit MF-7)

The results of the foundation's price survey were considered at the June 21, 1977, meeting of its Board of Trustees (J.A. 267-68 ¶ 301; C.R. 7(b), Exhibit MF-4), and various methods were discussed for increasing the foundation's fee schedule. (J.A. 268 ¶ 302). Although most of the surgeons and surgical specialty societies which had responded to the original April 14 letter had indicated that they would be satisfied with an increase to only $10.00, the board recommended to the members of the foundation that the surgical conversion factor be increased to $10.50. (J.A. 275-76). This increase was approved by the foundation's membership (J.A. 277-78) and went into effect December 1, 1977. (J.A. 268 ¶ 304). As a result of this series of events, all surgical procedures were thereafter compensated on the basis of the foundation's new $10.50 conversion factor rather than the $9.50 conversion factor which had previously applied. Comparable increases went into effect simultaneously for the other medical specialties. (J.A. 268 ¶ 304).

Agreed-Upon Increases in "Relative Values" Result in Increases in the Prices for Specific Medical Procedures

A "relative value" applies only to a particular medical procedure. If the only prices to be increased are those for a relatively limited number of procedures then such price

increases are accomplished through increases in the relative values of those few procedures instead of changing the conversion factor. An example involving two relatively common gynecological procedures will illustrate how changes in relative values are used to effect price changes for particular medical procedures.

At its September 20, 1976, meeting the foundation's Board of Trustees discussed the relative value used for diagnostic laparoscopies (J.A. 254 ¶ 255) and decided to request the opinion of the Phoenix Obstetrical and Gyneological Society on the usual doctor's fee for this procedure. (J.A. 255 ¶ 256). As a result of the foundation's request, "[t]he subject of fees for the diagnostic laparoscopic examination were discussed with the members of the Phoenix Obstetrical and Gynecological Society .... It was the unanimous opinion of the members present that the fee for diagnostic laparoscopy ought to be raised to par with that of laparoscopic tubal cauterization [or tubal ligation]." (C.R. 7(b), Exhibit MF-58). At the January 17, 1977, meeting of the foundation trustees a decision was reached to review all prices being charged for laparoscopies and to present a compilation to the board at its next meeting. (C.R. 7(b), Exhibit MF-54).

The review of the laparoscopy fees for diagnostic laparscopies and tubal ligation by laparoscopies was considered by the foundation's board at its February 21, 1977, meeting. (C.R. 7(b), Exhibit MF-51). Although the average fee for diagnostic laparoscopies was $266.05 and the median fee only $250.00, the foundation approved an increase in the conversion factor for this procedure so that the allowable price would be $275.00. (C.R. 7(b), Exhibits MF-48 and -51; J.A. 258-59 ¶¶ 269-73). To the same effect, the conversion factor for tubal ligation was changed to allow a price of $325.00 even though the median fee for this procedure was $300.00 and the average fee $315.53. (C.R. 7(b), Exhibits MF-48 and -51; J.A. 259 ¶¶ 274-76). Thus, for each of these procedures, the foundation established a fee level higher

than what it knew to be the average and median fees for the particular procedure involved. The amount physicians received for performing laparoscopies was thus increased from $190.00 to $275.00. (J.A. 254 ¶ 255; 258-59 ¶ 272). Comparable increases have been effected for other medical procedures. (*E.g.*, J.A. 256-57 ¶¶ 261-63).

Proceedings Below

The State of Arizona brought this action seeking declaratory and injunctive relief against the establishment and use of agreed-upon fee schedules by medical doctors in violation of section 1 of the Sherman Act, 15 U.S.C. § 1. The District Court's jurisdiction was invoked under 28 U.S.C. §§ 1331 and 1337 and section 16 of the Clayton Act, 15 U.S.C. § 26. Following completion of relevant discovery, the State of Arizona moved for partial summary judgment on liability on the ground that defendants' price-fixing activities were a *per se* violation section 1 of the Sherman Act, 15 U.S.C. § 1. The District Court denied this motion on June 5, 1979.[10] It reasoned that *Continental T.V., Inc. v. GTE Sylvania, Inc.*, 433 U.S. 36 (1977), established a trend away from the *per se* rule and that the *per se* rule would no longer be applicable to price-fixing agreements. Alternatively, it interpreted *Goldfarb v. Virginia State Bar*, 421 U.S. 733 (1975), and *National Society of Professional Engineers v. United States*, 433 U.S. 679 (1978), to mean that the *per se* rule could never be applied against professionals, even in a horizontal price-fixing case such as this. Subsequent motions for reconsideration of this order and for partial summary judgment on liability based upon the Rule of Reason were also denied. (Pet. App. E). On August 8, 1979, the district court certified for interlocutory appeal pursuant to 28 U.S.C. § 1292(b) its "determination that the Rule of Reason approach should be used in analyzing the chal-

[10] Pet App. D. This order also denied defendants' motions to dismiss the complaint and granted plaintiff's motion for partial summary judgment on the issue of subject matter jurisdiction. Only that portion of the order which addressed the issue of liability was appealed.

lenged conduct ... to determine whether a violation of Section 1 of the Sherman Act has occurred." (Pet. App. F).

A divided panel of the Court of Appeals affirmed with Judges Sneed and Kennedy each writing individual opinions and Senior District Judge Larson filing a dissent. *Arizona v. Maricopa County Medical Society*, 643 F.2d 553 (9th Cir. 1980). Judge Sneed followed the district court in holding that the *per se* rule could not be applied to the anticompetitive activities of doctors. Relying on *Broadcast Music, Inc. v. Columbia Broadcasting Co.*, 441 U.S. 1 (1979), and distinguishing *United States v. Socony-Vacuum Oil Co.*, 310 U.S. 150 (1940), Judge Sneed reasoned that it was impossible to determine whether the doctors' fee schedules were *per se* unlawful without first determining whether the agreed-upon prices were unreasonably high, unreasonably low, or were higher than other fee schedules.[11] Even if the doctors' fee schedules were viewed simply as establishing maximum prices, Judge Sneed was unwilling to hold them *per se* unlawful. He declined to follow *Albrecht v. Herald Co.*, 390 U.S. 145 (1968), and *Kiefer-Stewart Co. v. Joseph E. Seagram & Sons*, 340 U.S. 211 (1951), saying, "This circuit has not extended those rulings to horizontal agreements that establish maximum prices." 643 F.2d, at 557n.4. Judge Kennedy concurred in a

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[11] Judge Sneed reasoned, "We do not know how health insurers such as Blue Cross *(sic)* fix their fee schedules in the relevant geographic area or whether the fees they offer exceed the appellees' maximum fees .... This makes it impossible to evaluate the pro- and anticompetitive aspects of a given feature of the total structure, although these aspects must be weighted together in determining whether a per se rule, or even the Rule of Reason, should brand the questioned feature illegal." 673 F.2d, at 558.

Judge Sneed went on to speculate that the doctors' agreed-upon fee schedules might be unreasonably low so as to discourage entry of new competitors or unreasonably high so as to exact a monopoly profit and that until the reasonableness of the foundations' fee schedules was determined it would be impossible to determine whether they were *per se* unlawful. *Id.*, at 558-559.

separate opinion, stating that a trial was necessary before the *per se* rule could be applied. *Id.*, at 560.

Senior District Judge Larson dissented. He rejected the reasoning of the district court and Judge Sneed "that per se rules were being supplanted by greater use of the rule of reason." He concluded that this was the sort of "naked price restraint" which had previously been adjudged illegal *per se* and that there was no peculiarity of the health care industry that justified the application of a less strict legal standard to defendants' conduct. And, finally, Judge Larson rejected the defense recognized by Judge Sneed that the reasonableness of the price is a defense to a price-fixing charge.[12]

SUMMARY OF ARGUMENT

The Court has repeatedly held that any agreement that "raised, lowered, or stabilized prices" is "beyond the pale" and *per se* unlawful under the Sherman Act. *United States v. Socony-Vacuum Oil Co.*, 310 U.S., at 221. While the non-commercial activities of the so-called learned professions might arguably be subjected to less stringent scrutiny than comparable anticompetitive schemes in other businesses, this Court has shown no hesitation in applying the *per se* rule to fee schedules agreed upon by professionals. *Goldfarb v. Virginia State Bar*, 421 U.S. 773 (1975); *United States v. Utah Pharmaceutical Association*, 371 U.S. 24 (1962); *United States v. National Association of Real Estate Boards*, 339 U.S. 485 (1950). The *per se* rule should likewise be applied to the physicians' fee schedules involved here. Even though the health care industry suffers from more

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[12] *Id.*, at 563-569. Judge Larson said, "I do not agree with the majority's belief that the relevant inquiry is whether fees are higher or lower as a result of the defendants' conduct. I am confident that the fee schedule does have the effect of raising prices, and that in its absence consumers would ultimately obtain less expensive medical care. The majority's emphasis on the level of fees, however, is a version of the 'reasonableness of prices' justification for price-fixing. This defense has been repeatedly rejected." *Id.*, at 568.

pervasive anticompetitive restraints than other industries and even though doctors' prices are increasing at a higher rate than prices in other sectors of the economy, these are affirmative reasons for applying the *per se* analysis to the doctors' price-fixing scheme and not, as the Ninth Circuit would have it, for applying a less rigorous test.

The Ninth Circuit's acceptance as a defense of the alleged reasonableness of the agreed-upon prices is an aberration in the antitrust law contrary to the decisions of this Court and every other Court of Appeals. *E.g., Catalano, Inc. v. Target Sales, Inc.*, 446 U.S. 643 (1980). To the same effect, the Ninth Circuit's refusal to apply the *per se* rule to horizontal agreements fixing maximum prices is contrary to the decisions of this Court and the other Courts of Appeals. *E.g., Kiefer-Steward Co. v. Joseph E. Seagram & Sons, Inc.*, 340 U.S. 211 (1951).

ARGUMENT

I.

AT LEAST IN THE CASE OF AGREED-UPON FEE SCHEDULES NEITHER THE HEALTH CARE INDUSTRY IN GENERAL NOR PHYSICIANS IN PARTICULAR SHOULD ENJOY ANY SPECIAL EXEMPTION FROM THE ANTITRUST LAWS

As early as 1950, this Court held that agreed-upon fee schedules for professional services were unlawful *per se*. *United States v. National Association of Real Estate Boards*, 339 U.S. 485 (1950). In *Goldfarb v. Virginia State Bar*, 421 U.S. 773 (1975), this Court reemphasized that members of learned professions were not exempt from the Sherman Act and held that fee schedules for legal services were unlawful.[13] *National Society of Professional Engineers v. United States*, 435 U.S. 679 (1978), involved a less obvious restraint than the fee schedules present in *Real Estate Boards* and *Goldfarb* but this Court nonetheless held that a professional society's rule

[13] 421 U.S., at 781-83, 786-88. *See also United States v. Utah Pharmaceutical Ass'n*, 371 U.S. 24 (1962) *affirming per curiam* 201 F. Supp. 29 (D. Utah 1962) (pharmaceutical fee schedules *per se* unlawful).

against competitive bidding was "illegal on its face" recognizing that "no elaborate industry analysis is required to demonstrate the anticompetitive character of such an agreement." 435 U.S., at 692. Judge Sneed's opinion flies in the face of these holdings.

Judge Sneed's opinion focuses upon the characteristics of the health care industry rather than the nature of the challenged agreement. He reasoned that because "an industry is widely deviant from a reasonably competitive model," 643 F.2d, at 556, anticompetitive practices might be tolerated here that would be unacceptable in other contexts. He even felt that the prices agreed upon by this cartel might be defended on the ground that those prices were reasonable.

Judge Sneed's analysis is a dangerous departure from established Sherman Act analysis which ordinarily focuses upon the nature of the challenged agreement rather than the peculiarities of an industry. *E.g., National Society of Professional Engineers v. United States*, 435 U.S., at 688. By applying a different and more tolerant standard in "an industry widely deviant from a reasonably competitive model," Judge Sneed's rationale makes effective antitrust enforcement most difficult in precisely those cases where it is most needed. And, by making the legality of a price-fixing agreement turn upon the reasonableness of the agreed-upon prices when compared with other prices being charged in the marketplace, Judge Sneed creates an insoluble dilemma for the antitrust prosecutor trying to decide where first to begin in an industry characterized by pervasive anticompetitive practices.

What is involved here is nothing less than a compact among competitors on the prices they will receive for their individual services. "[T]o the extent that they raised, lowered, or stabilized prices they would be directly interfering with the free play of market forces. The [Sherman] Act places all such schemes beyond the pale and protects that vital part of our economy against any degree of interference. Congress has not left with [the courts] the deter-

mination of whether or not particular price-fixing schemes are wise or unwise, healthy or destructive." *United States v. Socony-Vacuum Oil Co.*, 310 U.S., at 221. Because the applicable inquiry focuses on the nature of the agreement and because the agreement here operates directly upon the prices charged, Judge Sneed's unprecedented approach should be rejected and respondents' conduct should be held to be *per se* unlawful.

That this case involves a so-called learned profession is certainly no reason for applying a different analysis, particularly since a price-fixing conspiracy has been alleged and proven. In *Goldfarb* and again in *Professional Engineers* this Court did, to be sure, leave open the theoretical possibility that some marginally anticompetitive activity which might be unlawful in another industry might be defensible if it occurred in one of the learned professions. Whether this is anything more than a theoretical possibility is yet to be established because this Court has not yet found any actual conduct by a learned profession which falls within this narrow theoretical description. In any event, the agreement involved in the present case is far removed from any theoretical possibilities which might have been contemplated in *Goldfarb* and *Professional Engineers*. The agreement here deals with the prices to be paid for goods and services. Price is the most central element of commerce and there is nothing about the health care industry which distinguishes it in this regard from any other industry.

Nor is there anything about the health care industry in general or physicians in particular which would justify a different treatment than that applied to other learned professions. No one disagrees with Judge Sneed's concern that price levels in the health care industry are artificially high. *See* 643 F.2d, at 556. This Court took notice in *Group Life & Health Ins. Co. v. Royal Drug Co.*, 440 U.S. 205, 232 n.40 (1979), that recently there has been "rapid escalation of health care costs to the detriment of consumers generally." Government studies of the health care industry and health

costs provide strong evidence of this fact[14] and such escalating costs certainly are no secret to those in need of medical services.[15] To the same effect, the Committee on Governmental Affairs in a study generally critical of the California Relative Value Studies, found that dramatic increase in health care costs to be of crisis proportions:

> One of the most crucial domestic problems facing the President and the Congress is the continuing increase in health care costs for our citizens. The statistics are startling. For example, in 1950, health care expenditures in our nation accounted for 4.5 percent of our Gross National Product. Total health care costs in Fiscal Year 1977 accounted for 8.8 percent of the Gross National Product or a total of $142.6 billion per year. The Department of Health, Education and Welfare has estimated that by 1980, we could be spending more than $230 billion per year for health care. This means that, in Fiscal Year 1977 $737 per year was spent for every man, woman and child for health care services and this figure could rise to $1,000 by 1980.
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> Almost 20 percent of all health care expenditures in Fiscal year 1977 — about $32 billion — was for professional services rendered by physicians. A considerable portion of this service was paid to physicians through

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[14] *See generally* Juba, *Price Setting in the Market for Physicians' Securities* [:] *A Review of the Literature*, Health Care Financing Grants & Contracts Report (Health, Educ. & Welfare Pub. No. (HCFA) 03012 9-79, 1979); Freeland, Calat and Schendler, *Projections of National Health Expenditures, 1980, 1985 and 1990*, 1 Health Care Financing Review, No. 3, 1-27 (1980); National Health Survey, Dept. of Health, Educ. & Welfare, *Family Out-of-Pocket Health Expenses, United States 1975*, (Public Health Service Pub. No. 51, 1979); Senate Committee on Governmental Affairs, *The California Relative Value Studies, An Overview*, 96th Cong. 1st Sess. (1979).

[15] *See* amici briefs in support of petition for a writ of certiorari by the Gray Panthers at vi, 6-7; American Association of Retired Persons and the National Retired Teachers Association at 2-3.

various health insurance programs, such as Blue Cross-Blue Shield, Medicare and Medicaid.[16]

Data published in a study by the Department of Health, Education and Welfare shows a 350 percent increase in national health expenditures from 1965 to 1978, reaching $192 billion in 1978.[17] This same study projects virtually runaway increases to $440 billion in 1985 and $760 billion in 1990.[18] In addressing the causes for such dramatic increases the study states:

> Two factors are particularly noteworthy: 1) the role of third-party payments in increasing consumer demand for services; and 2) the associated fee-for-service and cost-based reimbursement systems which lack incentives to provide medical care in the least expensive manner.[19]

To recognize with Judge Sneed that health care costs are increasing at an alarming rate and that there may be other conspiracies operating in the marketplace which result in even higher prices is certainly no excuse or justification for the anticompetitive conduct involved here. As Justice Douglas so aptly put it in *United States v. Crescent Amusement Co.*, 323 U.S. 173, 188 (1944), "[T]he fact that there may be somewhere in the background a greater conspiracy from which flow consequences more serious than we have here is no warrant for a refusal to deal with the lesser one which is before us." If prices in the health care sector

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[16] Senate Committee on Governmental Affairs, *The California Relative Value Studies, An Overview*, 96th Cong., 1st Sess., at 5 (1979).

[17] Freeland, Calat and Schendler, *supra* note 14 at 1. The increase, computed at a compound annual, is 12.2 percent, as compared to a 9.0 percent growth rate for the Gross National Product. *Id.*

[18] *Id.*, at 1, 6.

[19] *Id.*, at 6. *See also In the Matter of American Medical Association*, CCH Trade Reg. Rep. ¶ 21,068 (F.T.C. 1979), *aff'd sub nom. American Medical Ass'n v. Federal Trade Comm'n*, 668 F.2d 443 (2d Cir. 1980), where the Commission determined that the AMA's ban on advertising reduced incentive to price competitively. CCH Trade Reg. Rep. ¶ 21,068, at 28-31.

are increasing at an alarming rate, it is a reason for enforcing the congressional policy in favor of competition rather than creating a judge-made rule authorizing deviation from the competitive norm.

Judge Sneed was correct to perceive that the supply and demand functions of the medical marketplace have been distorted by high barriers to entry and government subsidies of the costs of medical care. But those characteristics are no more prevalent in the health care industry than in the petroleum industry, the railroad industry, and a host of other industries which this Court, as Congress intended, has held to be subject to the Sherman Act. *E.g., Northern Pacific R. Co. v. United States*, 356 U.S. 1 (1968); *United States v. Socony-Vacuum Oil Co.*, 310 U.S. 150 (1940). To allow these factors to justify an exemption from the *per se* rule in price-fixing cases would be tantamount to repeal of that rule.

But even if the pecularities of the medical marketplace were relevant, they would only underscore the inappropriateness of having organized medicine control the price-setting mechanism. Much of the distortion in the medical marketplace can be traced to the anticompetitive practices of traditional medical associations[20] which have aroused the concern of this Court,[21] as well as the Congress,[22] the

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[20] *See generally* Goldberg and Greenberg, *The Effect of Physician-Controlled Health Insurance*, 2 J. of Health Politics, Policy and Law, 48 (1977); Havighurst, *Professional Restraints on Innovation in Health Care Financing*, 1978 Duke L.J. 303.

[21] *Group Life & Health Ins., Co. v. Royal Drug Co.*, 440 U.S. 205, 232 n.40 (1979), and 440 U.S. at 253 (Brennan, J., dissenting.)

[22] *E.g., Skyrocketing Health Care Costs: The Role of Blue Shield*, Hearing before the Subcommittee on Oversight and Investigations of the House Committee on Interstate and Foreign Commerce, 95th Cong., 2d Sess., 4-34 (1978).

regulatory agencies,[23] and numerous commentators[24] who have unanimously concluded that professional price restraints, including the very foundation fee schedules challenged here,[25] are and should be unlawful *per se*. In contrast to the absolute control over prices demonstrated by the foundations in the present case, the flowering of a competitive marketplace for health care in Minneapolis-St. Paul has demonstrated the benefits of price competition among doctors.[26] Recent experience has also shown that competing insurers can take meaningful steps to contain health care costs in an open market protected by the antitrust laws.[27]

Finally, the foundations here cannot point to any unique circumstances of their own to justify exemption from the normal *per se* rules. The foundations cannot argue that their fee agreements are ancillary because to be lawful an ancillary restraint must be subordinate and necessary to another legitimate transaction. *See* R. Bork, *The Antitrust*

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[23] *E.g., In the Matter of American Medican Ass'n*, No. 9064 (F.T.C. 1979) (initial decision); Kass & Paulter, Federal Trade Commission Staff Report on Physician-Control of Blue Shield Plans (November 1979); Council on Wage and Price Stability, *Physicians' Fees, A Study of Physicians' Fees* (1978) (C.R. 66, Exhibit 2).

[24] Havighurst and Kissam, *The Antitrust Implications of Relative Value Studies in Medicine*, J. Health Politics, Policy and Law 48, 75-77 (Winter 1979); Horan and Nord, *Applications of Antitrust Law to the Health Care Delivery Systems*, 9 Cumberland L. Rev. 685, 700 (1979); Canby and Gellhorn, *Physician Advertising: The First Amendment and the Sherman Act*, 1978 Duke L.J. 543, 578; Havighurst, *Professional Restraints on Innovation in Health Care Financing*, 1978 Duke L.J. 303; Weller, *Medicaid Boycotts and Other Maladies from Medical Monopolists*, 11 Clearinghouse Rev. 99, 104 (1977); Note, *The Professions and Noncommercial Purposes*, 11 U. Mich. J. of Law Reform 387 (1978).

[25] Kallstrom, *Health Care Cost Control by Third Party Payors: Fee Schedules and the Sherman Act*, 1978 Duke L.J. 645.

[26] See Faltermayer, *Where Doctors Scramble for Patients' Dollars*, FORTUNE MAGAZINE 114 (Nov. 6, 1978).

[27] *Cf., Group Life & Health Ins. Co. v. Royal Drug Co.*, 440 U.S. 205 (1979). *See* Havighurst, *Controlling Health Care Costs*, 1 J. Health Politics, Policy & Law 471 (1977).

Paradox at 27 (1978). The foundations can and do perform all of their other functions without their members' entering into fee agreements, 642 F.2d, at 555, and the fee agreements thus cannot be considered ancillary to a legitimate transaction. The ordinary rules of *per se* illegality should therefore be applied here.

II.

AGREEMENTS AMONG COMPETITIORS ESTABLISHING PRICE SCHEDULES ARE *PER SE* UNLAWFUL WITHOUT REGARD TO THE REASONABLENESS OF THE PRICES AGREED UPON

The Ninth Circuit rejected application of the *per se* rule, with Judge Sneed stating, "The relevant inquiry becomes whether fees paid to doctors [absent agreed-upon fee schedules] would be less than those payable under the FMC maximum fee agreement." 643 F.2d, at 556. To make this "relevant inquiry," Judge Sneed suggested comparisons with other fee schedules used in the medical marketplace;[28] an analysis of respondents' own fee schedules to determine whether they were so high as "to capture a greater share of potential monopoly profit" *id.*, at 557, or "sufficiently low to discourage entry by potential competitors", *id.*, at 558; and a comparison of "the present supply and demand functions and those which would exist under ideal competitive conditions." *Id.*, at 556. By adopting a

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[28] 643 F.2d, at 558. Justice Stewart's majority opinion in *Group Life & Health Ins. Co. v. Royal Drug Co.*, 440 U.S., 205, 232 n.40 (1979), noted,

> Recent studies have concluded that physicians and other health care providers typically dominate the Boards of Directors of Blue Shield plans. Thus there is little incentive on the part of Blue Shield to minimize costs, since it is in the interest of the providers to set fee schedules at the highest possible level. This domination of Blue Shield by providers is said to have resulted in rapid escalation by health care costs to the detriment of consumers generally.

With a cloud already hanging over the legality and reasonableness of Blue Shield's fee schedules, the Blue Shield fee schedules are hardly a reliable benchmark for judging the legality or reasonableness of respondents' fee schedules.

construction of the Sherman Act that the legality of a price-fixing scheme turns on whether prices might have been lower in the absence of the conspiracy, the Ninth Circuit broke with the law as set forth both by this Court and the other courts of appeals.[29]

In the recent reversal of another of Judge Sneed's "rule of reason" analyses in *Catalano, Inc. v. Target Sales, Inc.*, 446 U.S. 643 (1980), this Court emphasized that "[i]t has long been settled that an agreement to fix prices is unlawful *per se*. It is no excuse that the prices fixed are themselves reasonable." 446 U.S., at 647, *citing United States v. Trenton Potteries Co.*, 273 U.S. 392, 397-398 (1927); *United*

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[29] *See, e.g.*, First Circuit: *Kartell v. Blue Shield of Mass., Inc.*, 592 F.2d 1191, 1193 n.2 (1st Cir. 1979); *Ford Motor Co. v. Webster's Auto Sales, Inc.*, 361 F.2d 874 (1st Cir. 1966); Second Circuit: *Ring v. Spina*, 148 F.2d 647 (2d Cir. 1945); *Connecticut Importing Co. v. Continental Distilling Corp.*, 129 F.2d 651 (2d Cir.), *cert. denied*, 317 U.S. 664 (1942); Third Circuit: *Wholesale Auto Supply Co. v. Hickok Manufacturing Co.* 221 F. Supp. [illegible] (D.N.J. 1963); *United States v. Vehicular Parking, Ltd.*, 54 F. Supp. 828 (D. Del. 1944); Fourth Circuit: *Virginia Excelsior Mills, Inc. v. Federal Trade Commission*, 256 F.2d 538 (4th Cir. 1958); *Pennsylvania Water & Power & Co. v. Consolidated Gas, Electric, Light & Power Co.*, 184 F.2d 552 (4th Cir.), *cert denied*, 340 U.S. 906 (1950). Fifth Circuit: *Alabama v. Blue Bird Body Co.*, 573 F.2d 309 (5th Cir. 1978); *Greene v. General Foods Corp.*, 517 F.2d 635 (5th Cir. 1975), *cert. denied*, 424 U.S. 942 (1976); *Denison Mattress Factory v. the Spring-Air Co.*, 308 F.2d 806 (6th Cir.) *cert denied*, 393 U.S. 983 (1968); *Barber-Coleman Co. v. Nat'l Tool Co.*, 136 F.2d 339 (6th Cir. 1943); Seventh Circuit: *Sun Oil Co. v. Federal Trade Commission*, 350 F.2d 624 (7th Cir. 1965), *cert. denied*, 382 U.S. 982 (1966); *Henry G. Meigs, Inc. v. Empire Petroleum Co.*, 273 F.2d 424 (7th Cir. 1960); Eighth Circuit: *Sun Oil Co. v. Vickers Refining Co.*, 414 F.2d 383 (8th Cir. 1969); Tenth Circuit: *United States v. Utah Pharmaceutical Ass'n*, 201 F. Supp. 29 (D. Utah), *aff'd*, 371 U.S. 24 (1962); District of Columbia Circuit: *United States v. Nat'l Soc'y of Professional Engineers*, 555 F.2d 978 (D.C. Cir. 1977), *aff'd*, 435 U.S. 679 (1978).

States v. Trans-Missouri Freight Ass'n, 166 U.S. 290, 340-341 (1897). The rationale for this rule had been explained by Justice Douglas in *United States v. Socony-Vacuum Oil Co.*, 310 U.S., at 221:

> Ruinous competition, financial disaster, evils of price cutting and the like appear throughout our history as ostensible justifications for price-fixing. If the so-called competitive abuses were to be appraised here, the reasonableness of prices would necessarily become an issue in every price-fixing case. In that event the Sherman Act would soon be emasculated; its philosophy would be supplanted by one which is wholly alien to a system of free competition; it would not be the charter of freedom which its framers intended.
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> The reasonableness of prices has no constancy due to the dynamic quality of the business facts underlying price structures. Those who fixed reasonable prices today would perpetuate unreasonable prices tomorrow, since those prices would not be subject to continuous administrative supervision and readjustment in light of changed conditions. Those who controlled the prices would control or effectively dominate the market. And those who were in that strategic position would have it in their power to destroy or drastically impair the competitive system. But the thrust of the rule is deeper and reaches more than monopoly power. Any combination which tampers with pice structures is engaged in an unlawful activity.

For the second time in a year, the Ninth Circuit has ignored that rule and followed an approach which examines the reasonableness of the prices agreed upon rather than stopping its inquiry when it found an agreement among competitors regarding prices. Any agreement among competitors tampering with the price structure should be *per se* unlawful and the Ninth Circuit was in error by authorizing inquiry into the reasonableness of the agreed-upon prices.

III.

AGREEMENTS AMONG COMPETITORS ESTABLISHING PRICE SCHEDULES SHOULD BE *PER SE* UNLAWFUL EVEN IF THE PRICE SCHEDULES ARE NOMINALLY TERMED "MAXIMUM" SCHEDULES

This Court has made it clear that maximum price-fixing is unlawful *per se*. "For such agreements, no less than those to fix minimum prices, cripple the freedom of traders and thereby restrain their ability to sell in accordance with their own judgment." *Kiefer-Stewart Co. v. Joseph E. Seagram & Sons, Inc.*, 340 U.S., at 213. *Accord, Albrecht v. Herald Co.*, 390 U.S., at 153; *California Retail Liquor Dealers Ass'n v. Midcal Aluminum, Inc.*, 445 U.S. 97 (1980). In no other circuit can competitors avoid the *per se* rule against price-fixing by denominating their agreed price level a "maximum." To the contrary, other circuits have expressly stated that horizontal maximum price-fixing is unlawful *per se*.[30]

Despite this persuasive authority, Judge Sneed held that, at least in the medical industry, maximum fee setting not only confers the benefit of a ceiling to prices, 643 F.2d, at 557, but that it also contributes to the "currently lively debate concerning 'limit-pricing' and predatory price-

[30] First Circuit: *Kartell v. Blue Shield of Mass, Inc.*, 592 F.2d 1191, 1193 n.2 (1st Cir. 1979); *Quinn v. Mobile Oil Co.*, 375 F.2d 273, 274, 276-278 (1st Cir.), *cert. dismissed*, 389 U.S. 801 (1967); Second Circuit: *Janel Sales Corp. v. Lanvin Parfums, Inc.*, 396 F.2d 398 (2d Cir.) *cert. denied*, 393 U.S. 938 (1968); *Vandervelde v. Put & Call Brokers & Dealers Ass'n*, 344 F. Supp. 118, 134 (S.D.N.Y. 1972); Fourth Circuit: *Virginia Excelsior Mills, Inc. v. Federal Trade Commission*, 256 F.2d 538 (4th Cir. 1958); Sixth Circuit: *Crane Distributing Co. v. Glenmore Distilleries*, 267 F.2d 543, 345 (6th Cir. 1959).

cutting."[31] Judge Sneed therefore declined to follow this Court's decisions in *Kiefer-Stewart* and *Albrecht*.

This Court and the other Circuit Courts have long recognized what the practice of the foundations here bears out: "an identical or parallel system of maximum prices between [competitors] is likely to become a system of minimum prices."[32] When maximum prices are set by a horizontal rather than a vertical agreement the anticompetitive consequences are even greater, and the tendency for the maximum price to function as a minimum price stronger, because the interests of the cartel are unchecked by the countervailing interests of any third party.[33] The facts of the instant case serve to illustrate this point—that is, there is no competitive bargaining regarding the cost of services between either the physicians or the foundations and the

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[31] 643 F.2d, at 557 n.4. At bottom of this determination appears to be Judges Sneed's perception of the benevolence of the physicians, as evidenced by his attribution by them of the term "good works" to the pricing agreements:

> We are by no means unaware that economic motives frequently lie behind even the best of good works. We are, however, simply not prepared to brand the appellees' conduct as "price fixing" and thus a per se violation of the Sherman Act on the basis of an unsupported *belief* that fee enhancement is the likely consequence of the appellees' maximum fee arrangement.

643 F.2d, at 557.

[32] *Quinn v. Mobile Oil Co.*, 375 F.2d 273, 277-78 (1st Cir. 1967) (Coffin J. concurring). *Accord, Albrecht v. Herald Co.*, 390 U.S. at 153 ("[I]f the actual price charged under a maximum price scheme is nearly always the fixed maximum price . . . that scheme tends to acquire all the attributes of an arrangement fixing minimum prices.")

[33] For this reason, informed commentators have urged that fee schedules promulgated by medical societies and their foundations for medical care "should be recognized as part of a profit-maximum strategy of a coalition of monopolists and held per se unlawful." Havighurst, *Professional Restraints on Innovation in Health Care Financing*, 1978 Duke L.J. 303, 377-378; Kallstrom, *Health Care Cost Control by Third Party Payors: Fee Schedules and the Sherman Act*, 1978 Duke L.J. 645, 678-680. *See also* Havighurst and Kissam, *The Antitrust Implications of Relative Value Studies in Medicine*, J. Health Politics, Policy and Law, 48, 68 (Winter 1979).

third-party payors.[34] The third-party payors have only the option of accepting the foundations' agreed-upon fee schedules or of not having their pre-paid health plans endorsed by the foundations. Such a result is the problem noted by this Court in *Group Life & Health Ins. Co. v. Royal Drug Co.*, 440 U.S., at 232 n.40:

> [E]xempting provider agreements from the antitrust laws would be likely in at least some cases to have serious anticompetitive consequences. Recent studies have concluded that physicians and other health-care providers typically dominate the boards of directors of Blue Shield plans. Thus, there is little incentive on the part of Blue Shield to minimize costs, since it is in the interests of the providers to set fee schedules at the highest possible level. This domination of Blue Shield by providers is said to have resulted in rapid escalation of health-care costs to the detriment of consumers generally.

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[34] *See generally* Havighurst and Hackbarth, *Private Cost Containment*, 300 New England J. of Medicine 1298 (1979); Havighurst, *Professional Restraints on Innovation in Health Care Financing*, 1978 Duke L.J. 303, for a discussion of the importance of such competitive bargaining.

To allow an exemption from the *per se* rule because the foundations denominate their fee schedules to set maximum prices[35] would be a virtual license to engage in all manner of anticompetitive practices. *See, e.g.*, note 5, *supra*. It would, for example, lend this Court's imprimatur to the agreed-upon increase for laparoscopies from $190.00 to $275.00 simply because this was nominally designated an increase in the allowable "maximum." Since the Sherman Act emphatically prohibits any sort of tampering by competitors with the competitive price structure, agreed-upon fee schedules should be *per se* unlawful no matter what they are called.

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[35] We assume, for the sake of argument, that respondents' fee schedules set maximum rather than minimum fees, but there is much to argue that what is involved here is a minimum or uniform fee schedule. This Court, in *Albrecht v. Herald Co.*, 390 U.S. 145, 153 (1968), recognized the principle that so-called ceilings on prices easily become floors:

> Moreover, if the actual price charged under a maximum price scheme is nearly always the fixed maximum price, which is increasing likely, as the maximum price approaches the actual cost of the dealer, the scheme tends to acquire all the attributes of an arrangement fixing minimum prices.

The record here is clear that the purpose of the letters, polls and meetings among the foundations and their members was to set one price for any given service. For example, a letter from Maricopa Foundation for Medical Care's president, Dr. Lawrence J. Shapiro admits, "The Maricopa Foundation for Medical Care is interested in maintaining as close-as-possible a relationship between the maximum allowance for Foundation plans and the usual and customary charges made by physicians in this area." CR 7(b), Exhibit MF-33. (Reply App. A) *See also* CR 7(b), Exhibits MF-3, MF-6 (Reply Apps. B and C) for further examples of the manner in which prices were set.

CONCLUSION

The judgment of the Court of Appeals should be reversed and the case remanded with instructions to enter partial summary judgment on the issue of liability in favor of petitioner.

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STATE OF ARIZONA

Petitioner,

vs.

MARICOPA COUNTY MEDICAL SOCIETY, MARICOPA FOUNDATION FOR MEDICAL CARE, AND PIMA FOUNDATION FOR MEDICAL CARE,

Respondents.

ON WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE NINTH CIRCUIT

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RESTATEMENT OF QUESTION PRESENTED

On Petitioner's motion for partial summary judgment the undisputed facts established an agreement among health care providers who are members of a Medical Foundation that (1) each would charge its individual customary fee, but (2) with respect to patients covered by health insurance endorsed by that Medical Foundation each would accept as payment in full the amount paid by that insurance and not to try to recover from the patient any difference between the insurance payment and the fee billed if the fee was higher than the maximum level of reimbursement established by the Foundation. Accordingly, it is submitted that the question presented must be restated as follows:

Did the Court of Appeals err in deciding that the agreement among Foundation members was not properly characterized by Petitioner as horizontal "price-fixing" (a *per se* violation of Section 1 of the Sherman Act) and that the action should proceed to trial to determine the economic effects of that agreement?

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No. 80-419

In the Supreme Court
OF THE
United States

OCTOBER TERM , 1980

STATE OF ARIZONA

Petitioner,

VS.

MARICOPA COUNTY MEDICAL SOCIETY, MARICOPA FOUNDATION FOR MEDICAL CARE, AND PIMA FOUNDATION FOR MEDICAL CARE,

Respondents

ON WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE NINTH CIRCUIT

JOINT BRIEF FOR RESPONDENTS

COUNTERSTATEMENT OF THE CASE

Proceedings Below

Contrary to Petitioner's claim, it did not await "*completion* of relevant discovery" to move for partial

summary judgment on the issue of liability.[1] Only two depositions have been taken by Petitioner.[2] Respondents objected in the District Court to Petitioner's effort to obtain summary judgment before Respondents had adequate discovery.[3] Respondents have taken no depositions as yet and Maricopa County Medical Society and Pima Foundation for Medical Care have not even initiated their discovery. The parties have filed affidavits in the District Court which conflict as to numerous material facts.[4]

The District Court's Decision

The District Court recognized the insufficiency of the undisputed facts in the record to support Petitioner's motion for partial summary judgment on the issue of liability by denying it on June 5, 1979 "with leave to file a similar motion based on additional evidence if appropriate."[5] The District Court's determination followed a two-pronged analysis. First, the court refused to apply

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[1]Pet. Br. at 12; emphasis added. Petitioner's motion (J.A. 40) was filed November 20, 1978, *preceeding*: (i) Respondents' answers to Petitioner's first set of requests for admissions and first set of interrogatories (dated December 4, 6 and 13, 1978); (ii) Petitioner's answers to Respondent Maricopa Foundation's first set of interrogatories and first set of demands for the production of documents (dated November 30, 1978); (iii) Petitioner's supplemental answers to Respondent Maricopa Foundation's first set of discovery requests (dated December 6 and 21, 1978 and July 13, 1979); and (iv) the deposition of Anthony D. Mitten (taken November 22, 1978; J.A. 297, 305).

[2]*I.e.*, the Deposition of Mary Gerdonics, filed November 20, 1978 (J.A. 34); and the Deposition of Anthony D. Mitten, filed December 27, 1978 (J.A. 297, 305).

[3]J.A. 484–88.

[4]See, *e.g.*, J.A. 31, 74, 88, 309, 332, 335, 404, 529, 532, 535, 538; C.R. 14, 37.

[5]Pet. App. D at 48.

blindly and mechanically the *per se* test demanded by Petitioner, recognizing that not all joint conduct should be characterized as a *per se* violation. The court cited *Continental T.V., Inc. v. GTE Sylvania, Inc.*, 433 U.S. 36 (1977) and *General Glass Co. v. Globe Glass & Trim Co.*, [1978-2] Trade Cas. (CCH) ¶ 62,231 (N.D. Ill. 1978).[6]

The second prong of the opinion recognized that, because the case concerns the medical profession, the court should give Respondents the opportunity to show that the challenged conduct promoted improvement of professional services to the public.[7] It relied upon *Goldfarb v. Virginia State Bar*, 421 U.S. 773, 778 n.17 (1975), *National Society of Professional Engineers v. United States*, 435 U.S. 679, 686 (1978), *Boddicker v. Arizona State Dental Association*, 549 F.2d 626, 632 (9th Cir.), *cert. denied*, 434 U.S. 825 (1977), and *Mackey v. National Football League*, 543 F.2d 606 (8th Cir. 1976), *cert. dismissed*, 434 U.S. 801 (1977). The District Court found that on the record before it on Petitioner's motion for partial summary judgment, Respondents' activities were more properly tested by a Rule of Reason analysis than by the rigid *per se* test for liability which would follow from accepting Petitioner's characterization of what it incorrectly claimed to be the undisputed material facts.[8]

The District Court subsequently denied Petitioner's motion for summary judgment and permanent

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[6]The District Court did not rule that *Continental T.V.* "established" a trend away from a *per se* approach, as claimed by Petitioner at page 12 of its Brief.

[7]Contrary to Petitioner's claim at page 12 of its Brief, the District Court did *not* intimate that *per se* analysis never applied to professionals.

[8]Pursuant to U.S.D.C., D. Ariz. R. 11(h), Respondents placed many of what Petitioner calls "undisputed material facts" in dispute. J.A. 123.

injunction on August 6, 1979, along with Petitioner's motion for reconsideration of the District Court's June 5, 1979 Memorandum and Order.[9] On August 8, 1979, the District Court amended its June 5, 1979 order to certify for interlocutory appeal pursuant to 28 U.S.C. § 1292(b) its denial of Petitioner's motion for partial summary judgment.[10] The only determination of the District Court to be reviewed on this writ is application of the Rule of Reason to the challenged conduct on a motion for partial summary judgment based on a record containing disputed material facts.[11]

The Court of Appeals' Decision

On November 19, 1979, the Ninth Circuit Court of Appeals issued an order which affirmed the pertinent District Court rulings and dissolved a limited stay which the Ninth Circuit issued pending determination of the appeal, District Judge Larson dissenting.[12] It stated that "[w]ith respect to the interlocutory appeal . . ., we conclude

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[9]Pet. App. E.

[10]Pet. App. F at 50.

[11]The August 6, 1979 denial of Petitioner's motion for summary judgment and permanent injunction was not appealed and is not before the Court. Petitioner never sought an evidentiary hearing with respect to its motion for preliminary injunction, but it appealed the order vacating the temporary restraining order on July 19, 1979. J.A. 482. The Ninth Circuit Court of Appeals' affirmance of that order is not before the Court on this writ.

Also, the District Court's earlier ruling denying Respondents' motion to dismiss based upon the McCarran-Ferguson Act, 15 U.S.C. § 1012 (1977), was not appealed and is not before the Court. *Arizona v. Maricopa County Medical Society*, 643 F.2d 553, 559 n.7 (9th Cir. 1980).

[12]Pet. App. C at 37. Petitioner does not challenge that portion of the Ninth Circuit's determination on this writ.

that *on the present state of the record* the [Respondents'] conduct should not be considered a per se violation of the Sherman Act, 15 U.S.C. § 1" and thus affirmed the denial of partial summary judgment.[13]

The Ninth Circuit's opinion, filed March 20, 1980, explained that, given the facts in the record on appeal, the court could not rule that the District Court erred in denying Petitioner's motion for partial summary judgment. The majority initiated its analysis by stating: "We must approach this appeal mindful that the Supreme Court has made it clear that the determination whether an agreement violates the Sherman Act turns on its 'impact on competitive conditions.' *National Society of Professional Engineers v. United States*, 435 U.S. 679, 688 . . . (1978). . . . The key, to repeat, is the agreement's impact on competition."[14]

The decision reemphasized that the *undisputed* facts adduced in limited pretrial discovery were inadequate to support a blind characterization of the challenged conduct as "price-fixing" subject to the *per se* standard:

> The State of Arizona insists that [Respondents'] practice . . . constitutes an arrangement without any redeeming virtue that suppresses and destroys competition and is thus unreasonable per se. The difficulty with [Petitioner's] position is that *this record reveals nothing about the actual competitive effects of the challenged arrangement* nor do the authorities, primary or secondary, afford assurance concerning its competitive impact. In truth, we know very little about the impact of this and many other arrangements within the health care industry.

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[13] *Id.*; emphasis added.

[14] 643 F.2d at 555–56.

> This alone should make us reluctant to invoke a per se rule with respect to the challenged arrangement.[15]

Judges Sneed and Kennedy looked to *Broadcast Music, Inc. v. Columbia Broadcasting System, Inc.*, 441 U.S. 1 (1979) for guidance. Citing to it, Judge Sneed noted "that whether to classify something as ' "*per se* price-fixing" . . . will often, but not *always*, be a simple matter.' "[16] He described some of the factual uncertainties which need clarification at trial:

> The issue whether to so classify the price schedules in this case is by no means "a simple matter." In addition to the uncertainties already referred to, we do not know how health insurers such as Blue Cross fix their fee schedules in the relevant geographical area or whether the fees they offer exceed the [Respondents'] maximum fees. *We are not informed by the record of the identity of, or the role played by, the various institutional components that compete in the relevant market.* One may *guess* that doctors, both within and without the FMC structure, insurance carriers, hospitals, and perhaps HMOs, operate within the market; *nonetheless, the record reveals nothing about the nature and extent of the competition between them. This makes it impossible to evaluate the pro- and anti-competitive aspects of a given feature of the total structure,* although these aspects must be weighed together in determining whether a per se rule, or even the Rule of Reason, should brand the questioned feature illegal.[17]

The majority opinions note repeatedly that "[h]ere the novelty of the market or markets *and the inadequacy of*

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[15] *Id.* at 556; emphasis added.

[16] *Id.* at 558; emphasis in original.

[17] *Id.*; emphasis added.

the record make an inquiry into the affected areas of competition *essential*"[18] and Judge Sneed concluded, "To

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[18]*Id.* at 558 n.5; emphasis added. See also, *e.g.*, *id.* at 557: ("We are, however, simply not prepared to brand the [Respondents'] conduct as 'price-fixing' and thus a per se violation of the Sherman Act on the basis of an unsupported *belief* that fee enhancement is the likely consequence of the [Respondents'] maximum fee arrangement.") (emphasis in original); *id.* at 556–57: ("Approached in this manner, the weakness of [Petitioner's] suggestion that a per se rule be employed here becomes apparent. To assume that the arrangement in question wrongfully increases fees requires the further assumption that the FMCs are but devices to enable the member doctors to capture a greater share of potential monopoly profit, which their monopoly power makes available, than otherwise would be possible. *This is an assumption we are not prepared to make on the basis of the record before us.*") (emphasis added); and *id.* at 556: ("[W]e lack baselines by which could be measured the distance between the present supply and demand functions and those which would exist under ideal competitive conditions.")

Judge Kennedy expressed the same factual concerns in his concurring opinion:

> I agree with my Brother Sneed that we know too little about the effects on competition produced by the practices here in question to brand them per se violations of the Sherman Act at this point. "It is only after considerable experience with certain business relationships that courts classify them as *per se* violations . . ." *United States v. Topco Associates, Inc.*, 405 U.S. 596, 607-08 . . . (1972). *We lack that experience in judging the maximum reimbursement schedules present here. . . .*
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> * * *
>
> Per se rules should be derived from considerations of economic impact in particular cases illustrating the category of prohibited acts, and *therefore a trial is appropriate to explore further the impact on competition of the challenged reimbursement schedules.*
>
> This is not to suggest, however, that I have found these reimbursement schedules to be per se proper, *that an examination of these practices under the rule of reason at trial* will not reveal the proscribed adverse effect on competition, or that this court is foreclosed at some later date, *when it has more evidence*, from concluding that such schedules do constitute per se violations.

Id. at 560; emphasis added.

affix the per se label to [Respondents'] conduct is, however, once more *to substitute an unsupported belief for proper proof.*"[19]

Petitioner simply failed to present sufficient undisputed facts to justify *per se* treatment of Respondents' challenged conduct on a motion for partial summary judgment (especially since professionals had only recently been brought within the purview of Section 1 of the Sherman Act).[20] The Circuit Court made it clear that Petitioner will have its opportunity to present sufficient evidence (if it exists) to establish liability *after* the parties have the opportunity to complete discovery.[21]

The Nature of Respondent Foundations for Medical Care

Respondents Maricopa and Pima Foundations are non-profit Arizona corporations established to provide competitive alternatives to utilization of closed panel prepaid health insurance plans.[22] Respondents act as the agents of participating insurers or self-insured groups[23]

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[19]*Id.* at 557; emphasis added.

[20]*Id.* at 556; citing *Goldfarb v. Virginia State Bar*, 421 U.S. at 785–88.

[21]See, *e.g.*, 643 F.2d at 558 n.5 (majority opinion) and 560 (J. Kennedy, concurring).

[22]J.A. 31 ¶ 2, 74 ¶¶ 3 & 4.

[23]Contrary to Petitioner's unsupported assertions in note 6 of its Brief, when a major employer such as Motorola, Inc. makes payments on Foundation endorsed insurance, it is accurate to refer to it as the insurer. Petitioner concedes those employers simply eliminate the insurance company as the underwriter of the actuarial risk and assume that risk themselves.

and as such they review the medical necessity and propriety of treatment rendered and, to the extent appropriate, pay the claim.[24]

Foundation member health care providers agree to accept as payment in full for patients covered by Foundation endorsed insurance the *maximum* level of reimbursement from the insurer for services rendered if they bill *more* than that level (and are paid *less* than that level if they bill less).[25] What the member health care provider is paid by the Foundation endorsed insurance may not fully compensate him or her for the services provided, but he or she cannot collect any more from the covered patient. On the other hand, non-members are free to obtain directly from the patient the difference between the maximum reimbursement paid and the amount of the bill.[26]

The District Court recognized that "the doctors who agree to participate in the foundation-approved plans are free to set the prices they charge their patients."[27] Physician members of a Foundation specifically agree that "participating membership in the foundation shall not affect the method of computation or amount of fees billed by me with respect to any medical care for any

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[24]J.A. 31 ¶ 2, 76 ¶ 9.

[25]J.A. 31 ¶ 3, 76 ¶ 10. Petitioner seeks to cloud the effect and intent of the challenged conduct by relying upon documents which call Foundation maximum reimbursement levels "uniform fee schedules". It is a fact that Foundation members are bound by their agreements with the Foundation not to use the maximum reimbursement levels to determine billings to patients. J.A. 31 ¶ 3, 514 ¶ 14. They are not "fee schedules" as that term is commonly understood or used in antitrust analysis.

[26]J.A. 76-77 ¶¶ 10-12.

[27]Pet. App. D at 39.

patient."[28] The members of Maricopa Foundation no longer vote on changes in the maximum reimbursement levels to be paid, which are established entirely by the Foundation's Board of Trustees.[29] The county Medical Society and the Foundation in that county have many members in common, but Respondent Foundations currently have no formal relationship with county Medical Societies.[30]

The agreements a Foundation enters into with insurers concern only the Foundation endorsed insurance they underwrite. Insurers are not compelled to write Foundation endorsed insurance, and therefore Foundations have no power to fix prices for medical services paid for by insurers. The insurers are free to write any other

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[28]J.A. 31 ¶ 3, 514 ¶ 14.

[29]The 1980 revision to Maricopa Foundation's by-laws gives its Board of Trustees power "to adopt reimbursement schedules for medical services, which when adopted by a majority vote of the Board of Trustees shall be binding upon all participating and cooperating members, of this corporation while, and so long as, they are participating and cooperating members in good standing of this corporation." App. A, By-Laws of the Maricopa Foundation for Medical Care, Revised as of January 25, 1980, at A-6.

[30]Petitioner erroneously states that the Maricopa County Medical Society is the Maricopa Foundation's "parent corporation." Pet. Br. at 2 n.1. While Maricopa Foundation was incorporated in 1969 by members of the Medical Society, the only structural link between the two corporations thereafter was a Maricopa Foundation by-law which provided that each person serving on the Medical Society's Board of Trustees automatically became an administrative member of the Medical Foundation. J.A. 189 ¶ 3; C.R. 7(b), Ex. MF-122 at 2. On January 25, 1980, the voting membership of Maricopa Foundation approved a revision of the by-laws of the Foundation. App. A at A-1. It eliminated the "administrative member" class of membership, removing that link. The Foundation's Board of Trustees is elected by the participating membership, not the county Medical Society. The consent judgment entered by Pima County Medical Society eliminated the links between it and Pima Foundation.

insurance on any other terms and may offer as alternatives to the same insureds Foundation endorsed and non-Foundation endorsed plans. While Petitioner attempts to create the impression that the Foundations are dominating forces in the "pre-paid health care market", in fact they are but one of many alternatives competing to provide health care.[31]

With respect to the Foundation endorsed plans, insurers agree to cover at least those medical services described in a Foundation's minimum standards and to reimburse health care providers for services rendered to insured patients in accordance with their usual and customary fees charged for such services but not to exceed the maximum level of reimbursement established by the Foundation, except at the insurer's discretion.[32]

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[31]*Cf.* J.A. 494–97. In its Brief at note 4 on page 5, Petitioner casually opines that certain ratios set out in a Foundation document dated October 11, 1974 "would indicate that the Maricopa Foundation had approximately 63 percent of the pre-paid health care market compared to 16 percent for health maintenance organizations and 21 percent for other indemnification plans." The cited letter indicates nothing of the kind. It concerns an informal survey of fewer than 13,000 people who worked for employers providing *multiple* options for health care. It simply points out that given free choice, they preferred the Foundation plan. C.R. 7(b), Ex. MF-90 at 2 ("As you can see, the Foundation is in most cases the choice of the individual subscriber.") A survey of this small, unrepresentative sample cannot establish competitors' shares of a "pre-paid health care market" for Maricopa County estimated to consist in 1974 of at least 1,500,000 persons. C.R. 68, Ex. A at 462. Petitioner's attempt to use the October 11, 1974 report as a market-share analysis is disingenuous. In 1979 Maricopa Foundation only claimed to insure about 100,000 lives in 48 groups. J.A. 407.

Nowhere in the record are there undisputed facts concerning the various competitors' shares of a health care market.The Ninth Circuit majority opinion found the record too inadequate to elucidate even the *identity* of the competitors in the market, much less their relative market shares. *Maricopa County Med. Soc'y*, 643 F.2d at 558 (quoted *supra* at 6).

[32]J.A. 129 ¶¶ 21–22.

The Foundations' use of defined dollar limits, rather than a variable level based on usual and customary fees, to determine maximum insurance reimbursement levels is essential to the concept and operation of Foundation insurance plans. The marketability of Foundation endorsed health insurance depends in large part on consumers' desire to purchase a health plan, such as Foundation endorsed insurance, which will pay 100% of physicians' charges for any given service.[33] Maricopa Foundation estimated when this action was brought that it had saved patients and their insurers over $6 million in medical fees;[34] Petitioner does not dispute that those reductions in medical costs have occurred.[35]

Patients insured by Foundation endorsed insurance plans need not go to Foundation members for treatment. They are free to enlist the services of any physician of their choice.[36] All health care providers were and are free to bill as they like and are treated the same whether or not they belong to a Foundation. Any physician treating a patient covered by Foundation endorsed insurance will be paid under the insurance in the same manner (*i.e.*, up to the Foundation's maximum level of reimbursement). Unlike *National Gerimedical Hospital and Gerontology Center v. Blue Cross of Kansas City*, 49 U.S.L.W. 4672 (U.S. June 15, 1981) and *Chalmette General Hospital, Inc. v. Louisiana Health Service & Indemnity Co.*, No. 78-1875 (E.D. La., filed June 9, 1978), there is no dual system of reimbursement at issue in this case.

In addition to free choice of physicians, the benefits to Foundation insured patients include the possibil-

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[33]J.A. 529 ¶ 3, 538 ¶ 3.

[34]J.A. 408.

[35]Maricopa Foundation estimates at this time that the savings in medical fees are well in excess of $8 million.

[36]J.A. 32 ¶ 4, 76 ¶ 10.

ity of lower insurance premiums (due to the savings insurers realize on payments to providers), assurance that if a Foundation provider member is used, the insured will not have to pay any difference between what the health care provider bills and what the insurance will reimburse (less any deductible in the insurance plan)[37] and knowledge that the health care provider will be discouraged from performing unnecessary treatment because a qualified peer will review the treatment performed to determine if it is medically necessary or appropriate.[38] Thus the Foundations offer a health care service different from that which individual physicians or individual insurers could separately provide to the public.

Petitioner Has Failed to Show Price-Fixing or Fee Uniformity

Petitioner failed to adduce on its partial summary judgment motion undisputed facts to support its price-fixing claims. Petitioner apparently relies solely upon the existence of Maricopa and Pima Foundations and their past use of relative value schedules and conversion factors voted on by their membership to establish maximum reimbursement levels.[39]

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[37]J.A. 76 ¶ 10, 129 ¶ 22.

[38]J.A. 31 ¶ 2, 76 ¶ 9.

[39]Contrary to Petitioner's assertion (Pet. Br. at 4), the record does *not* demonstrate that the Foundations consult with different medical specialty associations to determine prices charged by their members and use that information to formulate fee schedules. The Foundations have only requested advice from representatives of specialty groups concerning changes which might be necessary to make Foundation maximum reimbursement levels for procedures rendered by member physicians more equitable. *See* J.A. 84 ¶ 11; C.R. 7(a), Ex. PF-182; C.R. 7(b), Ex. MF-27 through MF-46; *see also*, J.A. 163 ¶ 44, 200 ¶ 44.

Maricopa Foundation's current standards include maximum reimbursement schedules of benefits which use neither relative values nor conversion factors.[40] That new schedule of benefits is an administrative document which is not circulated or distributed to the Foundation's membership. The Foundation does not provide a tabulation of its maximum reimbursement levels to its member health care providers. Pima Foundation took similar action in 1980 to establish maximum reimbursement levels without using conversion factors and relative values.

Petitioner itself currently prepares and circulates both relative value schedules and conversion factors used to determine payments by Arizona to physicians for their services in, *inter alia*, workmen's compensation cases.[41] In many instances, Petitioner's maximum reimbursement levels have been higher than the Foundations'.[42]

No Evidence Supports Petitioner's Claim That the Foundations' Maximum Reimbursement Levels Were Intended to Act as Uniform Fee Schedules or Raise Physicians' Fees

Petitioner did not present undisputed factual support for its assertion on its summary judgment motion that the Foundations' maximum levels of insurance reimbursement either are intended to be uniform schedules of fees physicians should bill their patients or have op-

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[40]App. B, Standards for Foundation-Endorsed Group Insurance Programs, as Amended April 1, 1980.

[41]J.A. 472–76 (Int. 22–25).

[42]J.A. 94 ¶ 8.

erated as such.[43] In fact, the maximum levels of reimbursement adopted by the Maricopa and Pima Foundations are substantially different.[44]

Petitioner states that "[t]he *ostensible* purpose of the foundation fee schedules is to establish 'the maximum level of reimbursement' that a foundation member may receive for services performed under a foundation-endorsed pre-paid health plan."[45] The record establishes that this is the *actual* and *only* purpose of the 'fee schedules' Petitioner attacks: "The sole purpose for which relative value schedules and conversion factors have been prepared or used by the Maricopa Foundation is in determining the maximum reimbursable levels of compensation for medical services provided to patients insured under Maricopa Foundation endorsed medical health in-

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[43]Petitioner claims that "[t]he record here is clear that the purpose of the letters, polls and meetings among the foundations and their members *was to set one price* for any given service." Pet. Br. at 28 n.35; emphasis added. However, that claim was disputed by Respondents on Petitioner's partial summary judgment motion. First, the only evidence of fees actually charged shows a bell curve distribution of charges, not "one price". J.A. 498-501. Secondly, the questioned conduct was used by the Foundation board of trustees solely to establish equitable conversion factors and relative values. They had to be sure that the Foundations' maximum reimbursement levels were not so low in relation to the members' current usual fees that the members would resign or refuse to renew their memberships rather than accept those maximum reimbursement levels as payment in full. *See, e.g.*, J.A. 88 ¶ 3, 127 ¶ 15, 163–64 ¶¶ 44–54, 200–02 ¶¶ 44–54, 229 ¶ 157, 239 ¶ 192, 261 ¶¶ 281–82, 521–22 ¶¶ 58 & 63; C.R. 7(a), Ex. PF-182; C.R. 7(b), Ex. MF-27 through MF-46; compare J.A. 333 ¶¶ 3–5, 335–36 ¶¶ 3–5, 530 ¶ 4, 532 ¶ 3, 535 ¶ 3, 538 ¶ 4.

[44]*Compare* J.A. 185 ¶ 413 *with* J.A. 268 ¶ 304.

[45]Pet. Br. at 5; emphasis added.

surance plans."[46] The undisputed facts simply do not establish any other purpose or use, whether nefarious or noble, for the Foundations' maximum reimbursement levels.

Petitioner boldly states that since "conversion factors apply to all medical procedures[,] . . . an increase in the conversion factors therefore results in an across-the-board increase in the doctors' prices."[47] However, there is no evidence in the record of any relationship at all between changes in the fees physicians in Maricopa and Pima counties charge their patients and changes in the Foundations' maximum reimbursement levels. The District Court could not tell from the record whether the Foundations' maximum reimbursement levels were increased by the Foundations *because* medical fees previously had gone up (as Respondents assert) or whether their increase by the Foundations *caused* medical fees to go up (as Petitioner asserts).[48]

Petitioner describes in detail in its Brief one specialty group's input into a Foundation's decision whether to change its "surgery" conversion factor. Nowhere in

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[46]J.A. 88 ¶ 2. *See also*, J.A. 32 ¶ 4, 75 ¶ 8, 76 ¶ 10, 78 ¶ 16, 82 ¶ 1, 125 ¶ 8, 128 ¶ 18, 129 ¶ 22, 152 ¶ 26, 159 ¶ 18, 208 ¶ 78, 309 ¶ 2, 496, 514 ¶ 14, 516 ¶ 37.

[47]Pet. Br. at 8.

[48]For example, Petitioner claims at page 7 of its Brief that ". . . once the fee schedules are established . . . foundation members revise their prices so that some 85 to 95 percent charge prices at or above those established by the fee schedules." There is absolutely no evidence of any causal relationship between Foundation maximum reimbursement levels and physicians' fees.

Petitioner's lopsided recounting[49] does Petitioner demonstrate that any doctor's fee changed as a result of the Foundation's decision to change its surgery conversion factor from $9.50 to $10.50. The record simply does not support Petitioner's claim that doctors raised their fees in response to conversion factor changes.

Similarly, the record contains absolutely no evidence that Foundation increases in the relative value it used for any procedure resulted in an increase in the fees physicians actually charged to perform services.[50] Petitioner only cites prevailing fees *preceeding* relative value increases.

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[49]As Petitioner would tell it, the Maricopa Foundation Board of Trustees raised the surgery conversion factor to $10.50 from $9.50 in spite of input from plastic surgeons and otolaryngologists. The Board, however, considered *all* surgical specialties in establishing the new conversion factor. Other specialties also transmitted their views to the Board.

The president of the Phoenix Urological Society stated, "I think without reservation one could say that your present charge of 9.5 dollars per unit is less than what most physicians are presently charging." C.R. 7(b), Ex. MF-6. He also stated that "most of the physicians were 10 to 11 with a few at 12, and only one physician was 9.5." *Id.* A representative of the Phoenix Obstetrical and Gynecological Society requested an increase in the factor to $10.50: "This would represent approximately a modest 5% increase each year for 1976 and 1977. Actual charges in the community now equal a conversion factor of $12.00 to $12.50 per unit." *Id.*, Ex. MF-8. An internist requested $12.50 (*id.*, Ex. MF-10) and four gastrointestinal specialists suggested that their procedures be reclassified as "medical", and thus subject to an $11.00 conversion factor (*id.*, Ex. MF-11). Of the otolaryngologists whose responses are in the court record, three requested a factor of $10.50 or greater (*id.*, Ex. MF-12, MF-13, MF-17 & MF-27).

Faced with this broad range of input, the Foundation board in good faith chose a conversion factor which certainly was not above prevailing fees.

[50]Compare Pet. Br. at 10–11 with J.A. 495–497.

The marketability of Foundation endorsed insurance depends upon its price being competitive with other health insurance.[51] Since increases in maximum reimbursement levels cause the insurers to make upward adjustments to insurance premiums,[52] the market price of health insurance is an effective restraint upon increases in maximum reimbursement levels. A Foundation cannot raise maximum reimbursement levels above those insurers use for non-Foundation insurance because no insurer would underwrite Foundation endorsed plans with such non-competitive rates.

The Foundations Did Not Adopt Maximum Reimbursement Levels Above the Average and Median Fees Prevailing in the Community

Petitioner claims that Maricopa Foundation's maximum reimbursement levels were above the prevailing average and median fees charged by physicians as evidenced by the Foundation's own survey.[53] The facts once again do not support Petitioner's assertion. The fee survey to which Petitioner refers was a *statewide* survey conducted by the Arizona Medical Association, not the Maricopa Foundation.[54] The figures include fees charged by rural Arizona medical practitioners[55] as well as the

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[51]J.A. 530 ¶ 6, 539 ¶ 7.

[52]*See* Lynk, *Regulatory Control of the Membership of Corporate Boards of Directors: The Blue Shield Case*, 24 J. Law & Econ. 159, 161 (1981) (hereinafter referred to as "Lynk").

[53]Pet. Br. at 7 & n.7.

[54]J.A. 248 ¶ 230; C.R. 7(b), Ex. MF-71 at 2.

[55]Petitioner would have the Court ignore the obvious fact that small town general practitioners charge less for services than more specialized and often better-trained and equipped metropolitan area physicians.

lower fees prevailing in Tucson (Pima County) as compared to Phoenix (Maricopa County).[56]

The 1977 increase in Maricopa Foundation's relative values for coronary bypass procedures is an example of the error in Petitioner's assumption.[57] The maximum allowable reimbursements were increased to levels *below* the fees prevailing in the county. The Maricopa Foundation Physicians Review Committee recommended that maximum reimbursement levels for single, double and triple coronary bypass procedures be increased to $2000, $2300 and $2600 respectively. The recommendation included a tabulation showing that average fees for those procedures in the Phoenix metropolitan area were $2000, $2353 and $2685.[58] Despite that recommendation, the Foundation Board of Trustees only increased the maximum reimbursement levels to $1900, $2137.50 and $2375 respectively.[59] Respondents seek an opportunity to prove at trial that reimbursement schedule changes such as these *contain* health care costs, rather than raise them.

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[56]The then-prevailing Pima Foundation conversion factors were all less than the corresponding Association survey average figures. *Compare* J.A. 248 ¶ 230 *with* J.A. 178 ¶ 364. Significantly, the 1976 conversion factors Petitioner attacks set a value of $12.00 for anesthesiology, a value *below* the $12.30 prevailing average indicated by the Association's survey. C.R. 7(b), Ex. MF-71 at 2. Inasmuch as anesthesiology is primarily a "big-city" specialty, the Association's "anesthesiology" average better represented the " 'prevailing average or median fee charged by physicians [*i.e.*, anesthesiologists] in the [Phoenix metropolitan] community' " than did the Association's figures relating to the more geographically dispersed "medicine" classification. Pet. Br. at 7 n.7; quoting Br. in Opp. at 4.

[57]Nevertheless, Petitioner cites the coronary bypass procedures' relative value increases to support its claim. Pet. Br. at 12.

[58]C.R. 7(b), Ex. MF-56.

[59]The relative vales of the procedures were increased to 200, 225 and 250 units. *Id.* at 2.

Similarly, on January 1, 1976, Maricopa Foundation adopted a revised maximum reimbursement schedule in which the relative values relating to maternity procedures were *all* reduced from those established in February 13, 1974 (although the conversion factors applied to all procedures had been increased).[60] As a result, maximum reimbursement levels for delivery procedures including antepartum care increased an average of only 0.7% annually between February 13, 1974 and January 1, 1976.[61]

It is worthy of note that in 1979 Pima Foundation's maximum reimbursement level for anesthesia services was based upon a conversion factor of $13.00 while its principal underwriter was using a conversion factor of $19.00 on non-Foundation insurance.[62] In his study of maximum reimbursement levels, William J. Lynk concluded that if physicians set that level, it will not exceed the median level of their charges. On the other hand, if insureds participate in setting maximum reimbursement levels, they tend to increase them significantly (to maximize their choice of physicians whose fees will be totally reimbursed).[63]

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[60] *Compare* N.R. 7(c), Ex. MF-120 (procedures 59400-59521) *with* C.R. 7(b), Ex. MF-99.

[61] For the purpose of comparison, it is worth noting that during the relevant period the Arizona consumer price index for "all items" increased an average of 7.2% annually (Hogan & Armstrong, *Consumer Prices: A Record Increase in 1980*, 28 Ariz. Bus. (March 1981) 3 at 5) and the national index for "all items" rose at an average annual rate of 7.7% (United States Bureau of the Census, *Statistical Abstract of the United States: 1980* (1981) at 436).

[62] J.A. 539 ¶ 5.

[63] Lynk at 161–62.

The Undisputed Evidence Shows That Foundation Minimum Standards and Maximum Reimbursement Levels Did Not Inflate Health Care Costs

The facts adduced during the limited discovery controvert Petitioner's unsubstantiated assertion that the "foundations' fee schedules . . . actually have had an inflationary impact which belies their characterization as 'maximum' fee schedules. . . ."[64] From August 1971 through June 1975, the conversion factors of Maricopa Foundation increased at an annual average rate of only 5.2%.[65] During that same period, national medical prices increased an average of 7.5% annually and the national consumer price index increased at an average of 6.9% annually.[66] From 1970 to 1974 the budget for a family of four in the Phoenix metropolitan area, *excluding* medical costs, increased an average of 6.9% annually, while the family's medical costs increased only 5.5% annually.[67]

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[64]Pet. Br. at 7. Petitioner also speculates that the Foundations' 1976 minimum standard setting a $50.00 annual deductible per insured for professional fees, criticized by Arizona as "relatively low", has inflationary effects. Pet. Br. at 6 n.5. This assertion is unsupported by the record and irrelevant to the issues of the case. It suggests Petitioner desires its citizens to pay more medical fees by decreasing their insurance coverage through larger deductibles, a most anomalous argument for a party which purports to represent the interests of the public. In this action Petitioner has only challenged the Foundations' setting of maximum reimbursement levels, not the policy deductibles. Its attacks by innuendo on Foundation practices which it has not seen fit to make issues in this litigation are inappropriate and irrelevant.

[65]These average annual increases ranged from 1.8% for the radiology conversion factor to 6.4% for the anesthesiology classification. *Compare* J.A. 211 ¶ 94 *with* J.A. 212 ¶ 96.

[66]C.R. 68, Ex. A at 434.

[67]*Id.* at 457.

The average annual increase in the maximum allowable reimbursement levels is *less* than the increases in the national and state consumer price indices for "all items".[68] Moreover, the Arizona consumer price index for "medical care" increased at an annual average rate *far below* that of both the Arizona index for "all items" and the national index for "physicians' services", "medical care" or "all items".[69] These relative annual inflation rates refute Petitioner's unsubstantiated claim that the Foundations' maximum reimbursement schedules had an inflationary impact on health care costs.

Since Petitioner itself circulates and promulgates higher maximum reimbursement levels than Respondents, it is hardly in a position to establish that Respondent Foundations' maximum reimbursement levels are inflationary.[70]

SUMMARY OF ARGUMENT

The courts below correctly held on the record before them that Petitioner's motion for partial summary judgment as to Respondents' alleged liability under Sec-

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[68]App. C, Comparisons of Changes in Average Conversion Factors and Consumer Price Indices, at C-1 through C-2.

[69]During the period 1973–1978, the Arizona consumer price index for "medical care" rose an average 1.7% annually while the national index for "physicians' services", "medical care", and for "all items", and the Arizona index for "all items" rose 12.3%, 11.9%, 9.4% and 8.3% respectively. *Id.*

[70]Maricopa Foundation had a contract with Arizona to administer the Comprehensive Medical/Dental Program for Foster Children. It made payments to physicians under that program pursuant to the maximum allowable fee schedule of Arizona's Department of Economic Security, which provided for *higher payments* than those which would have been made under Maricopa Foundation's own maximum levels of reimbursement to doctors providing services to patients insured under Maricopa Foundation endorsed health insurance plans. J.A. 526 ¶ 83. See also the discussion *supra* at 14.

tion 1 of the Sherman Act should be denied. The undisputed facts adduced by Petitioner were insufficient to establish a *per se* price-fixing conspiracy. The maximum reimbursement levels used by Medical Foundations only were shown to limit payments by insurers to Foundation members, decreasing the cost of health insurance. No effect on prices physicians charge patients was demonstrated. Petitioner did not even establish the identity of Respondents' competitors for a relevant market. Moreover, Petitioner itself was shown to engage in the very conduct it seeks to enjoin.

Respondents should have the opportunity to have discovery and prove at trial that the challenged practices are reasonable. They are pro-competitive because they enable Respondents to provide health care consumers with a uniquely desirable product which could not exist unless the Foundations themselves establish the maximum levels of reimbursement to be paid. The result is demonstrable reduction in medical costs. The courts below correctly followed recent decisions of the Court requiring reasoned analysis to determine the appropriate test to apply to challenged conduct, rather than precipitous application of the *per se* rule. *E.g., Broadcast Music, Inc. v. Columbia Broadcasting System, Inc.*, 441 U.S. 1 (1979); *Continental T.V., Inc. v. GTE Sylvania, Inc.*, 433 U.S. 36 (1977). The judicial system has not amassed sufficient experience with the health care field to summarily dismiss Respondents' justifications for the challenged arrangements, particularly since the practices of a profession are being scrutinized. *Goldfarb. v. Virginia State Bar*, 421 U.S. 773 (1975); *National Society of Professional Engineers v. United States*, 435 U.S. 679 (1978).

Furthermore, since Petitioner merely seeks prospective injunctive relief against the challenged practices, this writ presents the Court with a moot question.

Respondents have permanently abandoned the conduct upon which Petitioner relies.

ARGUMENT

I. THE UNDISPUTED FACTS ESTABLISHED ON PETITIONER'S PARTIAL SUMMARY JUDGMENT MOTION DO NOT CONSTITUTE A *PER SE* VIOLATION OF SECTION 1 OF THE SHERMAN ACT

Arizona's petition rests upon a fundamental misapprehension as to the proper result under applicable law because of its sweeping disregard of the facts in this case. Petitioner's Statement in its brief distorts the facts almost beyond recognition. It has attempted to affix conclusory, simplistic and misleading labels to a complex factual setting[71] in an unsuccessful effort to condemn the Respondent Foundations' actions as a *per se* illegal "horizontal maximum price-fixing" combination.[72]

Petitioner has not proven "a compact among competitors on the prices they will receive for their individual services."[73] Petitioner nevertheless urges this Court to hold Respondents' conduct *per se* unlawful, "[b]ecause the applicable inquiry [in cases of this sort] focuses on the nature of the agreement and because the agreement here operates directly upon the prices charged".[74] It seeks to assume away its burden of proof.

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[71]There is substantial dispute among the parties as to many of the facts which Arizona deems material. See J.A. 123, 511.

[72]*E.g.*, Pet. Br. at 25.

[73]*Id.* at 16.

[74]*Id.* at 17.

Respondents have shown *supra* that contrary to Petitioner's claim[75] the Foundations have no control over, and there is no evidence of any effect on, the fees physicians charge patients. No undisputed evidence supports Petitioner's hypothesis that the Foundations have monopoly power over the marketplace.[76] The Foundations do not unilaterally set the prices insurers pay physicians.[77] While Petitioner asserts "a price-fixing conspiracy has been alleged and proven",[78] there is no evidence that the Foundations control the fees charged by either member or non-member physicians.[79] Physicians specifically agree that "participating membership in the Foundation shall not affect the method of computation or amount of fees billed by me with respect to any medical care for any patient."[80]

Respondents do not dispute that an agreed upon fee schedule setting prices charged for professional services would be unlawful *per se*. Unlike the situation in *Goldfarb v. Virginia State Bar*, 421 U.S. 773 (1975), where a mandatory minimum fee schedule with respect to the prices to be charged for legal services was found to violate

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[75]See *id.* at 21, where Petitioner states that the Foundations in the present case possess a demonstrated "absolute control over prices".

[76]See note 31, *supra*.

[77]The Foundation minimum standards do not prevent any insurer from bargaining for a fee from an individual member physician which is lower than the Foundation's maximum reimbursement level. Member physicians are free to enter into any agreement they want with insurers or self-insuring health care consumers. Indeed, insurers are also free to pay more than the maximum reimbursement level under a Foundation endorsed plan. J.A. 129 ¶¶ 21–22.

[78]Pet. Br. at 17.

[79]*See, e.g.*, J.A. 31 ¶ 3, 514 ¶ 14.

[80]J.A. 31 ¶ 3, 514 ¶ 14.

Section 1 of the Sherman Act, there is no proof of uniform pricing here. In that case the Court said:

> A purely advisory fee schedule issued to provide guidelines, or an exchange of price information without a showing of an actual restraint of trade, would present us with a different question . . . .[81]

Petitioner has failed to carry its burden of establishing undisputed facts showing that Respondents' conduct raised, lowered or stabilized fees charged for medical services. Instead, Petitioner relies entirely on theoretical hypotheses in journal articles, unsupported by any facts.[82]

As in *Blue Cross and Blue Shield of Michigan v. Michigan Association of Psychotherapy Clinics* [1980-2], Trade Cas. (CCH) 63,351 (E.D. Mich. 1980), the maximum reimbursement levels at issue here are not "price fixing", because the health care providers are free to set their fees as they choose and no interference with the pricing mechanism has been shown. Compare *Pharmacist Political Action Committee of Maryland v. Harris,* [1980-81] Trade Cas. (CCH) ¶ 63,886 at 78,593 (D. Md. 1980) (HEW maximum allowable cost "regulations do not force pharmacists to sell at a specified price; they merely limit the amount the government will pay. . .", therefore they are not "price-fixing").

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[81]421 U.S. at 788 n.17.

[82]The Brief for the United States also assumes, without any proof, that the challenged conduct has "the practical effect of minimum price agreements", and that doctors have no financial incentive to charge less than Foundation maximum reimbursement levels. Brief at 8–9. Those assumptions are rebutted by William J. Lynk, who found that when doctors cannot discriminate against insured patients in their fees, the effect is to hold down insurance reimbursement levels. Lynk at 161–62.

As the Court has stated, summary procedures should be used sparingly in antitrust litigation, especially where the district court

> cannot say on [the] record that "it is quite clear what the truth is." It is only when the witnesses are present and subject to cross-examination that their credibility and the weight to be given their testimony can be appraised. Trial by affidavit is no substitute for trial by jury which so long has been the hallmark of "even handed justice."

Poller v. Columbia Broadcasting System, Inc., 368 U.S. 464, 472-73 (1962). As in *Poller*, the District Court "look[ed] at the record on [partial] summary judgment in the light most favorable to . . . the party opposing the motion, and concluded here that it should not have been granted."[83] It correctly found that on the facts currently in the record of this case, precedents holding that price-fixing is illegal do not compel unthinking application of a *per se* rule to Respondents to establish antitrust liability.

Notwithstanding Petitioner's claims, the Court of Appeals in no way required Petitioner to meet a new or unreasonably burdensome standard of proof. It only held that more evidence needed to be in the record before the trial court could determine if the Respondents' conduct should be found to be illegal price-fixing. Numerous decisions of this Court make it clear that not all horizontal agreements allegedly affecting price are *per se* unlawful. "*Per se* rules of illegality are appropriate only when they relate to conduct that is manifestly anticompetitive."

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[83] 368 U.S. at 473.

Continental T.V., Inc. v. GTE Sylvania, Inc., 433 U.S. 36, 50-51 (1977).[84]

Catalano, Inc. v. Target Sales, Inc., 446 U.S. 643 (1980), cited extensively by Petitioner, is irrelevant.[85] The *Catalano* case involved the question of characterization of an agreement among wholesalers to fix credit terms in which the Court held "credit terms must be characterized as an inseparable part of the price."[86] The Court ruled that the Ninth Circuit had erred in not making that characterization.

In observing that "It has long been settled that an agreement to fix prices is unlawful *per se*. It is no excuse that the prices fixed are themselves reasonable."[87] the Court cited *United States v. Trenton Potteries Co.*, 273 U.S. 392, 397–98 (1927); *United States v. Trans-Missouri Freight Association*, 166 U.S. 290, 340–41 (1897); and

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[84]The United States argues that a *per se* rule should be applied because "judicial inquiry into the effect on prices of maximum price agreements would be virtually impossible as a practical matter. . . ." Brief at 17. It is respectfully submitted that federal courts have frequently undertaken much more difficult tasks and brought them to a reasonable resolution. If the United States' argument were taken seriously, a Sherman Act Section 2 case could never be brought to judgment.

[85]Respondents note in passing that Petitioner appears to attempt to impugn the authority of the Ninth Circuit's decision in this action by implying that the reasoning of Judge Sneed should be rejected simply because *Catalano, Inc. v. Target Sales, Inc.*, 605 F.2d 1097 (9th Cir. 1979), *rev'd*, 446 U.S. 643 (1980), a case on which his decision in this action nowhere relied, was overruled. Such reasoning is, of course, spurious and improper. Attempts to inject the *Catalano* decision by claiming that Respondents asserted to the Ninth Circuit that *Catalano* required a Rule of Reason approach (*e.g.*, Brief for the United States at 5) are a strained effort based upon an unjustifiable interpretation of Respondents' briefs to that Court.

[86]446 U.S. at 648.

[87]*Id.* at 649.

United States v. Socony-Vacuum Oil Co., 310 U.S. 150 (1940). In none of those cases did plaintiff prevail on a motion for summary judgment. In each instance (except the *Trans-Missouri Freight* decision which only remanded the action for further proceedings after the complaint had been dismissed) a determination that the defendant's conduct was unlawful under the Sherman Act took place only after completion of discovery and a trial on the merits. The same is true of *Sugar Institute v. United States*, 297 U.S. 553 (1936), *National Society of Professional Engineers v. United States*, 435 U.S. 679 (1978), *Federal Trade Commission v. Cement Institute*, 333 U.S. 683 (1948), and the other cases cited by the Court in support of its decision in *Catalano*.

Unlike the situation in *Catalano*, Respondents in this action have argued the pro-competitive justification of offering a cost effective competitive alternative to closed panel prepaid medical plans with Foundation endorsed insurance, something which individual physicians could not separately attempt to do.[88] Respondents further urge as a pro-competitive justification that the effect of the Foundation medical plans is to decrease the cost of medical insurance without any demonstrable effect upon the prices which physicians charge their patients.

Furthermore, the *Catalano* case dealt with acts in a purely commercial industry. In contrast, the challenged conduct in this action concerns pricing in the medical profession. See *Veizaga v. National Board for Respiratory Therapy*, [1977-1] Trade Cas. (CCH) ¶ 61,274 (N.D. Ill.

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[88]Note 8 to the *Catalano* decision made it clear that "Respondents nowhere suggest a pro-competitive justification for a horizontal agreement to fix credit. Their argument is confined to disputing that settled case law establishes that such an agreement is unlawful on its face." *Id.* at 646 n.8.

1977), where the court denied plaintiff's motion for summary judgment, holding that determination of whether the questioned conduct was professional or commercial could not be made before trial. As in *White Motor Co. v. United States*, 372 U.S. 253 (1963), this action should be remanded for further proceedings.

In reality, Petitioner attempts to avoid *any* standard of proof, not merely a burdensome one. It would have the Court make a facile determination that Respondents' conduct is "price-fixing" and thus *per se* illegal, when both the District Court and the Ninth Circuit have found the evidence insufficient at this stage in the proceedings to support that determination.

A. *Since Petitioner Failed to Establish a Horizontal Price-Fixing Conspiracy The District Court Did Not Err in Denying Partial Summary Judgment*

In a carefully reasoned opinion, the District Court concluded "that the Rule of Reason approach should be used in analyzing the challenged conduct in the instant case. Choosing the Rule of Reason approach precludes granting the [Petitioner's] motion for partial summary judgment on the issue of liability because there is insufficient evidence as to the purpose and effect of the allegedly unlawful practices and the power of the [Respondents]."[89] Petitioner has failed to demonstrate that the District Court erred in choosing to apply the Rule of Reason test to analyze Respondents' conduct. Instead it attacks the language of Judge Sneed's opinion affirming that determination as if Judge Sneed were the respondent on this writ.

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[89]Pet. App. D at 47.

In affirming the District Court's ruling, the Ninth Circuit simply allowed Respondents an opportunity to show the reasonableness of their conduct at trial. That is perfectly consistent with the case law and does not establish any new "reasonableness of the price" defense as Petitioner contends. A careful reading in their entirety of the majority opinions affirming the denial of summary judgment inevitably leads to the conclusion that at this early stage in the proceedings insufficient undisputed evidence has been introduced by Petitioner to convince either the District Court or the Circuit Court that the conduct at issue should simply be called "price-fixing".

The courts' determinations are amply supported by numerous decisions of the Court which make it clear that not all horizontal agreements affecting price are unlawful on their face. In *Broadcast Music, Inc. v. Columbia Broadcasting Systems, Inc.*, 441 U.S. 1 (1979), the Court rejected the simplistic *per se* approach to antitrust analysis favored by Petitioner. Holding that the Rule of Reason should govern the determination of the legality of the blanket licensing practice at issue (which had been held to be *per se* illegal price-fixing by the Court of Appeals), the Court observed that while the *per se* rule "is a valid and useful tool of antitrust policy and enforcement", courts must not be too quick to seize upon it as a replacement for reasoned analysis of challenged practices: "[E]asy labels do not always supply ready answers."[90]

Petitioner's rush to affix the label of horizontal price-fixing to the Foundations' practices stands at odds with the searching analysis mandated by *Broadcast Music*:

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[90] 441 U.S. at 8.

> To the Court of Appeals and CBS, the blanket license involves "price fixing" in the literal sense: the composers and publishing houses have joined together into an organization that sets its price for the blanket license it sells. But this is not a question simply of determining whether two or more potential competitors have literally "fixed" a "price". As generally used in the antitrust field, "price fixing" is a shorthand way of describing certain categories of business behavior to which the *per se* rule had been held applicable. The Court of Appeals' literal approach does not alone establish that this particular practice is one of those types or that it is "plainly anticompetitive" and very likely without "redeeming virtue." Literalness is overly simplistic and often overbroad. . . .
>
> Consequently, [citation omitted] "[i]t is only after considerable experience with certain business relationships that courts classify them as *per se* violations. . . ."[91]

The Court concluded that "[n]ot all arrangements among actual or potential competitors that have an impact on price are *per se* violations of the Sherman Act or even unreasonable restraints."[92]

Broadcast Music is the most recent in a line of cases including *Continental T.V., Inc. v. GTE Sylvania, Inc.*, 433 U.S. 36 (1977), in which the Court, overruling its earlier decision in *United States v. Arnold, Schwinn & Co.*, 388 U.S. 365 (1967), condemned the precipitous application of the *per se* rule when not appropriate to a particular antitrust case. The Court noted that *Schwinn* itself "was an abrupt and largely unexplained departure from *White Motor Co. v. United States*, 372 U.S. 253, 83

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[91] *Id.* at 8–9.

[92] *Id.* at 23.

S. Ct. 696, 9 L. Ed. 2d 738 (1963), where only four years earlier the Court had refused to endorse a *per se* rule for vertical restrictions."[93]

In rejecting the truncated *per se* analysis employed in *Schwinn*, the Court plainly insisted that courts focus on the substantive orientation of the antitrust laws in analyzing particular cases, declaring: "Realities must dominate judgment. . . . The Anti-Trust Act aims at substance."[94] The Court emphasized that "[*p*]*er se* rules of illegality are appropriate only when they relate to conduct that is manifestly anti-competitive"[95] and warned: "[W]e . . . make clear that departure from the rule of reason standard must be based upon demonstrable economic effect rather than—as in *Schwinn*— upon formalistic line drawing."[96] Petitioner asks the Court to disregard that admonition by applying conclusory labels to the Foundations' activities and blindly applying the *per se* rule with no showing of "demonstrable economic effect".

There is no showing by Petitioner of any causal link between Respondents' challenged conduct and the fees charged by doctors. The journals cited by Petitioner contain theoretical arguments made in a vacuum, without any attempt at empirical verification. On the other hand, William J. Lynk's recent study which reviewed empirical data establishes that when physicians set maximum reimbursement levels for health insurance plans, the levels are likely to be *lower* than if the levels are set

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[93]*Continental T.V.*, 433 U.S. at 47.

[94]*Id.*, quoting *Appalachian Coals, Inc. v. United States*, 288 U.S. 344, 360 (1933).

[95]433 U.S. at 49–50.

[96]*Id.* at 58–59.

by others: "The principal empirical finding is that greater physician representation on plan boards generates reductions in both the maximum and average levels of reimbursement."[97] Respondents should be given an opportunity to demonstrate at trial that their conduct in the particular factual circumstances of this case has the salutory effect predicted by Lynk's theory and the general empirical evidence.

As the Court noted in *White Motor Co. v. United States*, 372 U.S. 253, 263 (1963), (and reiterated, in substance, in *Broadcast Music*),[98] "We need to know more than we do about the actual impact of these arrangements on competition to decide whether they have a 'pernicious effect on competition and lack . . . any redeeming virtue' [citation omitted] and therefore should be classified as *per se* violations of the Sherman Act". Here there has been too little antitrust experience with the Medical Foundation concept of offering a lower cost alternative health insurance plan to blindly apply, as Petitioner would, a rigid *per se* analysis in the present case. The District Court was correct in refusing to do so.

The antitrust laws were not intended to straitjacket imaginative experimentation in fields such as the professions not traditionally subject to antitrust scrutiny. In *Goldfarb*, the Court went out of its way to state

> The fact that a restraint operates upon a profession as distinguished from a business is,

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[97]Lynk at 160. Reliance by the authors cited by Petitioner on Kass & Paulter, Federal Trade Commission Report on Physician Control of Blue Shield Plans (1979), makes their findings suspect. Lynk shows that the F.T.C. study used dummy variables based on assumptions which prove unsupported by the empirical data. The F.T.C. results are statistically unsound. See Lynk at 171–72 n.19.

[98]441 U.S. at 10 & 16.

> of course, relevant in determining whether that particular restraint violates the Sherman Act. It would be unrealistic to view the practice of professions as interchangeable with other business activities, and automatically to apply to the professions antitrust concepts which originated in other areas. The public service aspect, and other features of the professions, may require that a particular practice, which could properly be viewed as a violation of the Sherman Act in another context, be treated differently. We intimate no view on any other situation than the one which we are confronted today.[99]

In *National Society of Professional Engineers v. United States*, 435 U.S. 679 (1978), the Court reiterated that "certain practices by members of a learned profession might survive scrutiny under the Rule of Reason even though they would be viewed as a violation of the Sherman Act in another context."[100] The Court then quoted in its entirety note 17 from the *Goldfarb* decision in the text of the *Professional Engineers* decision.

The District Court's decision to apply the Rule of Reason in this case was further mandated by the Ninth Circuit's decision in *Boddicker v. Arizona State Dental Association*, 549 F.2d 626 (9th Cir.), *cert. denied*, 434 U.S. 825 (1977).

> [T]he Supreme Court does not require that the practices challenged here be treated the same as would be proper if dentistry were merely a commercial enterprise.
>
> As we interpret the Court, to survive a Sherman Act challenge a particular practice, rule, or regulation of a profession, whether rooted in

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[99]421 U.S. at 788 n.17.

[100]435 U.S. at 686.

> tradition or the pronouncements of its organizations, must serve the purpose for which the profession exists, *viz.* to serve the public. That is, it must contribute directly to improving service to the public. Those which only suppress competition between practitioners will fail to survive the challenge. This interpretation permits a harmonization of the ends that both the professions and the Sherman Act serve.
>
> We recognize this interpretation provides only the principle to be employed in deciding specific cases. It is not a blueprint which will resolve all controversies and by which the professions can check their structures to determine whether they comply with the Sherman Act. Any such blueprint must await additional guidance by the Supreme Court and resolution of specific cases by this and other courts.[101]

The Ninth Circuit correctly stated the rule in *Boddicker* and correctly applied the rule to Petitioner's partial summary judgment motion.

Contrary to Petitioner's assertion, Judges Sneed and Kennedy agreed that the further evidence which would be adduced at trial might convince the trial court to classify the Respondents' challenged conduct as "price-fixing" which in future cases could be subject to a *per se* standard of liability. They simply found a *per se* analysis inappropriate at the summary judgment stage of these proceedings, noting that the professions had only recently been brought within Section 1 of the Sherman Act[102] and that guidelines for professional conduct are still being written.

As Judge Kennedy stated, "[p]er se rules should be derived from considerations of economic impact in par-

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[101] 549 F.2d at 632.

[102] 643 F.2d at 556; citing *Goldfarb*, 421 U.S. at 785–88.

ticular cases illustrating the category of prohibited acts and therefore a trial is appropriate to explore further the impact on competition of the challenged reimbursement schedules."[103]

B. *Medical Foundation Endorsed Insurance Plans Are a Unique Product Which Cannot Exist Unless Maximum Reimbursement Levels for the Insurance Are Established by Medical Foundations*

The Foundation endorsed insurance plans are, it is respectfully submitted, subject to the same type of analysis as the blanket licenses in the *Broadcast Music* case. As in that case, Petitioner has failed in this action to establish any agreement by competitors concerning prices they will sell at on an individual basis. A Foundation endorsed insurance plan is a health care service different from that which any individual physician or individual insurer could separately provide the public.

As in *Broadcast Music*, as a practical matter it is impossible for an individual insurer to negotiate with a large proportion of the physicians in a community to establish uniform standards for medical care and uniform defined dollar limits for maximum reimbursement levels which would bind the treating physician.[104] Foundation endorsed insurance is unique in guaranteeing to the insureds 100% payment of physicians' bills (after the payment of a deductible) for treatment from a large number of physicians in private practice in the community, and in providing this service through a number of insurers at competitive insurance premiums. It is something no individual doctor or insurer could do.[105]

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[103]643 F.2d at 560.

[104]Compare 441 U.S. at 5.

[105]Compare *id.* at 23.

Respondents have urged and are prepared to prove at trial that, as in *Broadcast Music,* Foundation endorsed health insurance results in substantial lowering of costs and, by providing insureds with a large number of participating physicians throughout the community, produces a "whole [which] is truly greater than the sum of its parts. . . ."[106] The empirical evidence suggests that physician control over reimbursement levels reduces those levels and increases physician willingness to accept lower levels of reimbursement as payment in full.[107] Petitioner concedes that, as in *Broadcast Music,* the "marketable package" of Foundation endorsed insurance is clearly preferred by many consumers.[108] The Court should not foreclose Respondents from proving that Foundation endorsed insurance is a type of conduct which should be praised and encouraged instead of being condemned in a knee-jerk reaction to "price-fixing".

In *Broadcast Music* the Court reiterated that the *per se* rule is not employed until after considerable experience with the type of challenged restraint.[109] When it is urged that Respondents must establish that their conduct is necessary[110] in order for them to prevail, it would be unfair to rule in Petitioner's favor on a motion for partial summary judgment made before Respondents are given an opportunity to conduct any meaningful discovery.

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[106]*Id.* at 21–22.

[107]Lynk at 170–71.

[108]See Pet. Br. at 5 n.4, discussed at note 31, *supra.*

[109]441 U.S. at 19 n.33.

[110]See, *e.g.*, Brief for the United States at 23.

II. THE WRIT IS MOOT BECAUSE PETITIONER RELIES UPON ALLEGED CONDUCT WHICH DOES NOT AND WILL NOT OCCUR

Among the factual allegations relied upon by Petitioner in its Brief are (i) membership voting on adoption of "fee schedules"[111] (ii) use of relative values and conversion factors as the components of a "fee schedule"[112] and (iii) Maricopa County Medical Society's appointment of Maricopa Foundation's governing Board of Trustees.[113]

As set forth above at page 10, as a result of changes in the by-laws of Maricopa Foundation, the Maricopa County Medical Society does not appoint the Foundation's governing board and Foundation members do not vote on maximum reimbursement levels. Also, the Foundations have moved away from use of relative values and conversion factors to determine their maximum reimbursement levels.

In view of the significant changes in the factual situation since Arizona brought this action in 1978, it would be inappropriate to find a violation of the Sherman Act and enter an injunction, as Petitioner requests, without further consideration of the case by the trial court in light of the intervening changes. *Fusari v. Steinberg*, 419 U.S. 379, 390 (1975) (remanding action in which District Court had entered an injunction "for reconsideration in light of the intervening changes in Connecticut law"). "The purpose of an injunction is to prevent future violations, *Swift & Co. v. United States*, 276 U.S. 311, 326 (1928), and, of couse, it can be utilized even without a

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[111]Pet. Br. at 4.

[112]*Id.*

[113]*Id.* at 2 n.1.

showing of past wrongs. But the moving party must satisfy the court that relief is needed. The necessary determination is that there exists some cognizable danger recurrent violation, something more than the mere possibility which serves to keep the case alive." *United States v. W.T. Grant Co.*, 345 U.S. 629, 633 (1953) (affirming dismissal of suit to enjoin violations of § 8 of the Clayton Act).

Since Petitioner does not seek any damages for alleged past violations, this case is moot unless it establishes a reasonable expectation that the allegedly wrongful behavior is likely to recur. *S.E.C. v. Medical Committee for Human Rights*, 404 U.S. 403, 406 (1972) This writ is from denial of partial summary judgment on a sparse record and the action simply should be remanded to the District Court for further proceedings to develop the current state of affairs and whether Petitioner has any right to relief under them. That is properly a matter for the trial court. *United States v. Concentrated Phosphate Export Association, Inc.*, 393 U.S. 199, 203-04 (1968).

III. NOT ALL HORIZONTAL MAXIMUM PRICE-FIXING IS A *PER SE* VIOLATION OF SECTION 1 OF THE SHERMAN ACT

Petitioner relies upon *Kiefer-Stewart Co. v. Joseph E. Seagram Co.*, 340 U.S. 211 (1951), *Albrecht v. Herald Co.*, 390 U.S. 145 (1968), and *California Retail Liquor Dealers Association v. Midcal Aluminum, Inc.*, 445 U.S. 97 (1980), to assert that all agreements among competitors with respect to maximum prices are *per se* unlawful. Respondents respectfully urge that there is no inconsistency between the denial of partial summary judgment in this action and the opinions cited by Petitioner.

In *Kiefer-Stewart*, the Court reinstated a jury verdict that unlawful maximum resale price-fixing had oc-

curred, citing only *United States v. Socony-Vacuum Oil Co.*, 310 U.S. 150, 223 (1940). Without any further discussion it stated, "[S]uch agreements, no less than those to fix minimum prices, cripple the freedom of traders and thereby restrain their ability to sell in acccordance with their own judgments."[114] However, as the Court later noted in *Albrecht v. Herald Co.*,[115] the maximum prices that were the object of the decision in *Kiefer-Stewart* were also minimum prices set under the fair trade laws of that time.[116]

While the Court stated in *Albrecht* its determination to "adhere to" the *Kiefer-Stewart* decision,[117] that determination was based in part upon the defendant's use of exclusive territories which were determined to be unlawful under *United States v. Arnold Schwinn & Co.*, 388 U.S. 365, 373 (1967).[118] Since the Court subsequently overruled the *Schwinn* case in *Continental T.V., Inc. v. GTE Sylvania, Inc.*, 433 U.S. 36 (1977), the rationale of *Albrecht* is therefore suspect.

The only other explanation which the Court gave for its determination that the maximum price fixing was illegal in *Albrecht* was that

> [m]aximum and minimum price fixing may have different consequences in many situations. But schemes to fix maximum prices, by substituting the perhaps erroneous judgment of a seller for the forces of the competitive market, may severely intrude upon the ability of buyers

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[114]340 U.S. at 213.

[115]390 U.S. at 153 n.9.

[116]See *Kiefer-Stewart Co. v. Joseph E. Seagram & Sons*, 182 F.2d 228, 230–31 (7th Cir. 1950), *rev'd*, 340 U.S. 211 (1951).

[117]390 U.S. at 152.

[118]*Id.* at 154; see also, *id.* at 150 n.6.

> to compete and survive in that market. . . . Maximum price fixing may channel distribution through a few large or specifically advantaged dealers who otherwise would be subject to significant nonprice competition. Moreover, if the actual price charged under a maximum price scheme is nearly always the fixed maximum price, which is increasingly likely as the maximum price approaches the actual cost of the dealer, the scheme tends to acquire all of the attributes of an arrangement fixing minimum prices.[119]

The latter part of the Court's rationale in *Albrecht* has no application here, since this case does not involve either resale by a dealer of goods sold by the party fixing the price nor a situation in which the maximum price is nearly always the price charged. Indeed, Petitioner complains loudly that 85 to 95 percent of the members of the Foundations charge more than the Foundations' maximum reimbursement levels.[120]

The other argument advanced in the *Albrecht* opinion is an unfortunate confusion between protecting competition and protecting competitors. The Court subsequently reaffirmed that the Sherman Act protects "competition, not *competitors*. . . ." *Brunswick Corp. v. Pueblo Bowl-O-Mat, Inc.*, 429 U.S. 477, 488 (1977); quoting *Brown Shoe Co. v. United States*, 370 U.S. 294, 320 (1962).

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[119]*Id.* at 152-53.

[120]Pet. Br. at 7. This high percentage of charges above the Foundation maximum reimbursement levels demonstrates that the Foundations work. In his study, William J. Lynk found that a typical Blue Shield's maximum reimbursement level is 15 to 20 percent above the median charge so that most doctors are paid in full by the insurers. Lynk at 162n.9. A Foundation endorsed insurer would not pay most fees in full.

Mr. Justice Douglas in his concurring opinion pointed out that *Albrecht* should be treated as a Rule of Reason case because it was factually close to *White Motor Co. v. United States*, 372 U.S. 253 (1963). As in *White Motor Co.* (which regained its vitality in the light of the Court's determination in *Continental T.V.* to overrule *Schwinn*), this action should be remanded for findings on the actual impact of the arrangements on competition. As Mr. Justice Harlan recognized in his dissent in *Albrecht*:

> When price floors and price ceilings are placed side by side, then, and the questions asked of each, "Does analysis justify a no-trial rule?" The answers must be quite different. Both practices share the negative attribute that they restrict individual discretion in the pricing area, but only the former imposes upon the public the much more significant evil of lessened competition, and, as just seen, the latter has an important arguable justification that the former does not possess [preventing resellers from reaping monopoly or supercompetitive profits]. As the Court's opinion partially but inexplicitly recognizes, in a maximum price case the asserted justification must be met on its merits, and not by incantation of a *per se* rule developed for an altogether different situation.[121]

Respondents' acts do not have any effect on prices charged by physicians to their patients. They only affect prices paid by insurers for services rendered to insureds covered by Foundation endorsed plans to the extent a Foundation member provider charges the patient more than the maximum reimbursement level. By limiting the insurers' costs, the maximum reimbursement levels tend to have a favorable effect upon the cost of premiums for

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[121] 390 U.S. at 159.

Foundation endorsed health insurance.[122] But since the Foundation endorsed insurance plans do not permit member providers to seek payment of the excess over that reimbursement level from the insured patient and do not permit physicians to discriminate in billing Foundation insured patients as compared to non-Foundation insured patients, the Foundation maximum reimbursement levels do not affect what any patient pays to physicians for medical services.[123]

In *Group Life & Health Insurance Co. v. Royal Drug Co.*, 440 U.S. 205 (1979), Blue Shield was accused of fixing the maximum prices for prescription drugs. Although the Court had the opportunity to examine the alleged maximum price-fixing of prescription drugs by Blue Shield, it declined the opportunity to do so.[124] In determining that Blue Shield was not exempt from the Sherman Act by Section 2(b) of the McCarran-Ferguson Act, the Court noted that, "The United States in its *amicus* brief urging affirmance has taken the position

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[122]The United States pointed out in its *amicus* brief in *Group Life & Health Ins. Co. v. Royal Drug Co.*, 440 U.S. 205 (1979), that maximum price-fixing "serves to help the policyholders find low-overhead pharmacies with which to deal. Moreover, it provides pharmacies with incentives to reduce their distribution costs in order to be able to take advantage of [the maximum price] and still make a profit. . . . Nothing in the antitrust laws requires drug purchasers (or Blue Shield acting as their purchasing agent) to offer the greater compensation necessary to satisfy less efficient pharmacies or suppliers interested in providing expensive but unwanted services at the point of sale. To the contrary, antitrust policy seeks to preserve to consumers the opportunity to obtain a better deal." Brief for the United States as *amicus curiae* at 11–12. Surprisingly the United States has taken an entirely different position in its *amicus* brief in this matter.

[123]Since physicians may want to charge less to attract additional non-Foundation patients, they have an incentive to charge less than the maximum reimbursement level to all patients.

[124]Compare *United States v. Utah Pharmaceutical Association*, 201 F. Supp. 29 (D. Utah), *aff'd*, 371 U.S. 24 (1962).

that the Pharmacy Agreements probably do not violate the antitrust laws, though recognizing that the issue is not presented here."[125]

To evade its argument's factual difficulty, Petitioner theorizes that the *likely* effect of the challenged conduct is an increase in what physicians bill. This hypothesis is buttressed by reference to articles written by certain theorists who have not verified their belief through empirical data. As Respondents have shown above, when empirical data is reviewed the results refute Petitioner's theory.

The cases upon which Petitioner relies deal with resale price maintenance in the context of agreements between suppliers and distributors. Whatever the merit of Petitioner's arguments in the resale price maintenance context, they are not valid in the context of agreements among suppliers entered for the limited purpose of establishing maximum insurance reimbursement levels for a separate service offered by them as a group. Compare *Broadcast Music, Inc. v. Columbia Broadcasting System, Inc.*, 441 U.S. 1 (1979).

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[125]440 U.S. at 210n.5.

CONCLUSION

The determination of the Court of Appeals to affirm denial of partial summary judgment by the District Court should be affirmed and the case remanded to the District Court for further proceedings.

Respectfully submitted,

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APPENDICES

APPENDIX A

BY-LAWS

OF THE

MARICOPA FOUNDATION FOR MEDICAL CARE

REVISED AS OF JANUARY 25, 1980*

CHAPTER I

GENERAL PROVISIONS AND PROPERTY INTERESTS

* * *

CHAPTER II

MEMBERSHIP

Section 1. Classes of membership:

There shall be the following classes of membership in this corporation: Participating, Cooperating and Health Care Institution Participating Members. These classifications shall not be mutually exclusive.

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*Only those revisions which altered the Maricopa Foundation By-Laws as revised August 14, 1972 (C.R. 7(b), Ex. MF-122) are reproduced *infra*. Identical provisions are indicated by "* * *".

Section 2. Qualifications of participating members:

* * *

Section 3. Rights and privileges of participating members:

Participating members shall have the privilege of holding any office in the corporation, and the privilege of membership on any committee of the corporation.

Section 4. Qualification of cooperating members:

* * *

Section 5. Rights and privileges of cooperating members:

The rights and privileges of Cooperating Members, including terms of membership shall be exactly the same as specified in Section 3 and 6 of this chapter with respect to Participating Members. Procedure for admission of Cooperating Members shall be exactly the same as provided in Section 7 of this chapter for admission of Participating Members. Cooperating Membership shall be non-transferrable and subject to the provisions of Section 8 of this chapter.

Section 6. Term of membership:

* * *

Section 7. Procedure for admission to participating membership:

Any person who desires to become a participating member of this corporation shall fill out and sign in duplicate the application blank provided for that purpose by the corporation. Such application blank shall be in the form or forms determined by the Board of Trustees, and shall contain a clause stating in substance that the applicant agrees to be bound by the constitution, by-laws, and rules and regulations of this corporation; that the applicant, as long as his membership in this corporation

is effective, agrees to be bound by any and all rules, regulations, reimbursement schedules, and the like, adopted by this corporation; and that the applicant realizes and understands that if he is elected to membership, his membership shall be for a period of only one year, or less, as the case may be and that if he fails to re-apply for membership in accordance with the constitution, by-laws and rules and regulations of this corporation, his membership shall automatically terminate on its expiration date.

Said application shall be filed with the secretary-treasurer at the principal office of the corporation. The application shall be referred by the secretary-treasurer to the membership committee, which shall investigate the background and present status of the applicant, and shall report to the Board of Trustees, with a recommendation thereon. At the next meeting of the Board of Trustees, the president shall announce the names of those applicants submitted to it by the membership committee, and the committee recommendation, if any. Each applicant shall thereupon be voted on individually; and it shall require a two-thirds majority vote of the Board of Trustees to elect to membership.

Not more than ninety (90) days, nor less than thirty (30) days prior to the uniform membership termination date, each participating member of this corporation who desires to become a participating member of the corporation for another year shall file an application therefor in duplicate with the secretary-treasurer at the principal office of this corporation. It shall be the duty of the secretary-treasurer to send application forms to each participating member of this corporation at least ninety (90) days prior to the expiration of his term of membership. The procedure for subsequent admissions' to participating membership in this corporation shall be the same and shall require the same vote as for initial admission to membership in this corporation.

At any time, any person qualified to apply for participating membership as specified in these by-laws may apply therefor in the manner outlined in this Chapter II; and if he is elected to membership, said membership shall terminate on the uniform membership termination date and applications for new membership must be made in accordance herewith.

Section 8. Non-transferability of membership:

* * *

Section 9. Membership roll:

* * *

Section 10. Health Care Institution Participating Membership:

* * *

CHAPTER III

MEETINGS OF MEMBERS

Section 1. Annual meetings:

Annual meetings of paricipating members shall be held on the third Monday in January each year. Notice of all annual meetings of members is hereby dispensed with.

Section 2. Regular meetings:

Regular meetings of the participating members shall be held at the time and place as determined by the Board of Trustees. Notice of all regular meetings of members is hereby dispensed with.

Section 3. Special meetings:

Special meetings of participating members, for any purpose or purposes whatsoever, may be called at any time by the president or the Board of Trustees; or by one-third of the members in that class. Notice of special meetings shall be given to each member entitled to vote thereat either personally or by mail addressed to such member at his address appearing upon the books of the corporation, at least ten (10) days in advance of the date of such special meetings; and such writen [sic] notice shall also state the place, day and hour of such meeting and the general nature of the business to be transacted. No business shall be transacted at a special meeting other than stated in the purposes set forth in the notice. Special meetings may be held at the principal office of the corporation, or at any other place within the County of Maricopa.

Section 4. Adjourned meetings, and notice thereof:

* * *

Section 5. Entry of notice:

* * *

Section 6. Consent of absentees:

* * *

Section 7. Action without meeting:

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CHAPTER IV

CORPORATE POWERS

Section 1. Corporate powers vested in Board of Trustees:

* * *

Section 2. Powers of Trustees:

Subject to these by-laws, the Board of Trustees shall have full and sole power to control and manage the property and conduct the affairs and business of this corporation; and in furtherance of the foregoing powers, but not in limitation thereof, it shall have power:

First: * * *
Second: * * *
Third: * * *
Fourth: * * *
Fifth: * * *
Sixth: * * *
Seventh: To consider, approve or disapprove all recommendations of any committees; and to adopt reimbursement schedules for medical services, which when adopted by a majority vote of the Board of Trustees shall be binding upon all participating and cooperating members, of this corporation while, and so long as, they are participating and cooperating members in good standing of this corporation.

CHAPTER V

BOARD OF TRUSTEES

Section 1. Terms of office:

The first trustees designated as such in the Articles of Incorporation of this corporation shall hold office

and exercise all powers granted to the Board of Trustees until the next regular annual meeting of this corporation. Thereafter, a new Board of Trustees shall be elected in accordance with these by-laws. The new Board of Trustees so elected may be composed of all, some, or none of the first trustees designated as such in the Articles of Incorporation. Four (4) members of said Board of Trustees shall be elected for a period of three (3) years, four (4) for a period of two (2) years, and four (4) for a period of one (1) year. Yearly thereafter four (4) new members shall be elected to the Board of Trustees of this corporation for a period of three (3) years.

Section 2. Removal from office:

* * *

Section 3. Vacancies:

* * *

Section 4. Composition of Board of Trustees:

* * *

CHAPTER VI

MEETINGS

Section 1. Regular meetings:

Regular meetings of the Board of Trustees shall be held without call on the third Monday of each and every month. Notice of all such regular meetings of the Board of Trustees is hereby dispensed with.

Section 2. Special meetings:

* * *

Section 3. Written consents and waivers of notice:

* * *

CHAPTER VII

OFFICERS

* * *

CHAPTER VIII

DUTIES OF OFFICERS

* * *

CHAPTER IX

EXECUTIVE COMMITTEE AND OTHER COMMITTEES ESTABLISHED BY TRUSTEES

Section 1. Executive Committee:

* * *

Section 2. Standing Committees:

Standing committees of this corporation shall be as follows:

a. Constitution and by-laws committee.
b. Membership committee.
c. Minimum standards committee.
d. Peer review committee.

Section 3. Qualifications and terms of office of committee members:

* * *

Section 4. Composition and duties of committees:

* * *

Section 5. Other committees:

* * *

CHAPTER X

ELECTIONS

Section 1. Board of Trustees:

First: The Board of Trustees shall conduct all elections, both regular and special, and shall be in charge of all matters pertaining thereto.

Second: The annual election of Trustees shall be held on the last day of November of each year.

Third: There shall be no ballot other than the official ballot as provided by the secretary. On each ballot, shall be printed, in alphabetical order, the names of the nominees for each office. After the name of each nominee shall be placed a line on which the voter shall make a mark to indicate the nominee for whom he chooses to vote.

Fourth: The secretary shall mail one official ballot with instructions to each qualified participating member of the Foundation within ten days after the October meeting of the Board of Trustees. A member ber voting must write his name on the official outside envelope which shall contain his ballot sealed in the official inside envelope. The official outside envelope shall remain sealed until the voter's

name has been checked off the list of qualified participating member voters by the secretary and when opened, the sealed inside envelope containing the ballot shall remain sealed and so be deposited in the official ballot box. Such ballot must be delivered, personally or by mail, at the polls before the hour of 5:00 p.m. on the day of the election. After the closing of the polls, the inside envelope shall be opened and the ballot shall be counted by the Board or a group of tellers authorized by the Board, provided, however, that at least one member of the Board of Trustees shall be present at the counting of the votes.

Fifth: The majority of the votes case on any ballot shall be necessary to elect. If more than two nominees appear on the ballot and no nominee receives the majority of the votes cast on the first ballot, all of the nominees except the two highest shall be dropped and a second mailed ballot shall be taken in the same manner as the first.

Sixth: In case the only two nominees for the office receive an equal number of votes, election shall be determined by lot in such manner as the Board of Trustees may prescribe and the person whose favor it shall result shall be declared duly elected.

Section 2. Officers:

* * *

Section 3. Nominating Committee:

First: The Nominating Committee of the Foundation shall be the members of the Executive Committee. The Nominating Committee shall choose its nominees by a majority vote of its members and shall report its nominations to the Board of Trustees at the September Board meeting of each year.

Second: These nominations shall be published to the participating members of the Foundation by the end of September of each year and additional nominations for the Board may be made from the membership prior to the October Board meeting of the Board of Trustees.

CHAPTER XI

MISCELLANEOUS

Section 1. Inspection of corporate records:

* * *

Section 2. Checks, drafts, etc.:

* * *

Section 3. Annual report:

* * *

Section 4. Contracts, etc. — how executed:

* * *

Section 5. Inspection of by-laws:

* * *

Section 6. Rules of order:

* * *

Section 7. Rules of Professional conduct:

Such principles of professional conduct as this corporation may adopt by a majority vote of its members, shall govern this corporation and all members thereof.

Section 8. Disciplinary action:

A member who is guilty of a criminal offense or gross misconduct, either as a physician or as a citizen, or violates any of the provisions of the Articles of Incorporation of this corporation or these by-laws, or any principles of professional conduct adopted by this corporation, or who acts contrary to or in violation of any contracts, agreements, or statements of principle of this corporation, shall be liable to censure, suspension or expulsion. The procedure to be followed by this corporation with respect to censure, suspension, or expulsion of a member shall be the procedure now or hereafter contained or provided in the by-laws of the Maricopa County Medical Society as now existing or as they may be hereafter amended; and said procedure is hereby incorporated into these by-laws by this reference; provided, however, that this corporation may, but shall not be required to, appoint a judicial council to hear disciplinary matters, if it so desires. Such judicial council, if appointed, shall be appointed by a majority vote of the Board of Trustees.

Section 9. Fiscal and Administrative Year:

* * *

CHAPTER XII

AMENDMENTS

* * *

APPENDIX B

MARICOPA FOUNDATION FOR MEDICAL CARE

STANDARDS FOR FOUNDATION-ENDORSED GROUP INSURANCE PROGRAMS

AS AMENDED

APRIL 1, 1980

* * *

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STANDARDS FOR ENDORSEMENTS GROUP INSURANCE PROGRAMS

I. GENERAL AND ADMINISTRATIVE

1. These Standards shall apply to all groups written with an effective date or renewal date on or after April 1, 1980. Unless otherwise stated, it is the intention of these Standards to cover expenses of accidents, illness or suspected illness. *Nothing in these standards shall be construed so as to prevent the insurance contract from conforming with the applicable state law.*

2. The schedule of benefits shall be in accordance with the enclosed maximum reimbursement schedule adopted by the Maricopa Foundation on April 1, 1980. Benefit payments for all professional services will be based on the lesser of the physician's usual fee or the maximum reimbursement schedule.

3. Contracts may be written covering the subscriber alone providing the contracts meet the Standards. If dependents are covered they may have less benefits than the subscriber, provided the dependent benefits at least meet the Standards. Dependent definition for Foundation-endorsed plans shall be: Insured spouse and unmarried children less than 19 years of age; or the insured's unmarried children under 23 years of age who attend an accredited educational institution on a full-time day basis and depend upon the insured for support and maintenance. Persons insured as employees under the same policy are not included as dependents.

Unmarried children 19 years or older who are prevented from pursuing normal activities due to mental retardation or physical handicap and who are wholly dependent on the insured for support and maintenance are also eligible for coverage. However, any individual eligible to be insured under a policy as a dependent shall

not be considered a dependent if in full-time military, naval or air service.

4. Claims review by the Foundation for Medical Care:

This is defined as meaning that the Foundation must receive all claims for review. These claims will be processed by the Foundation and drafts executed under draft authority from the various underwriters.

The Foundation shall be paid a percentage of the group's accident and health premium for physician peer review of claims, processing claims and executing drafts. For this service the Foundation is to receive 4% of the premium per contract year. This fee should be paid to the Foundation on a monthly basis as the premium is received from the group. The percentage of premium applies whether or not the Foundation has draft authority.

If it is the desire of the underwriter that the Foundation office be responsible for certification of eligibility then an additional fee of 1/2 of 1% of the annual premium may be charged by the Foundation.

Claim forms and other forms used by the underwriter shall meet with Foundation approval. *The American Medical Association's uniform claim form is preferred.*

During the contract year, if the Foundation is not allowed to keep the original claim file for a reasonable time, the underwriter must reimburse the Foundation for the cost of duplication of the file.

5. Professional payments to be restricted to duly licensed:

a. Physicians and Surgeons
(Doctors of Medicine)
b. Doctors of Dentistry.

c. Physicians and Surgeons
(Doctors of Osteopathy)
d. Doctors of Podiatry
(Podiatrists)

(Unless otherwise provided by law)

6. No program shall be deemed to meet Foundation specifications unless the proposal is accompanied by a letter of approval from the Foundation for Medical Care or a letter from the Insurance Company or Service Plan stating the plan meets the Foundation standards. If granted, such approval shall be for a period of one year and a copy of the proposal shall be filed with the Foundation for Medical Care. If an insurance company wishes to file with the Foundation a letter stating that all specifications do, in fact, meet Foundation standards such a blanket letter will take the place of individual approval of each and every proposal.

7. Annual review of the program for Foundation approval must be secured prior to the renewal date of the contract. Any proposed rate changes shall be made known to the Foundation at the time the underwriter seeks said annual approval. The insuror will automatically give the Foundation at the start of each policy year the number of employees covered, and an estimate of the expected annual premium income, and will provide copies of the periodic experience reports normally provided to the brokers, agent and/or group.

8. If the Standards for Foundation endorsement are met and the Foundation endorses the program, participating members of the Foundation thereby agree with the following:

To accept as payment in full, payments in accordance with the schedule adopted by the Foundation's Board of Trustees.

If the physician is a member of the Foundation for Medical Care, assignment of benefits

will be automatic and payment made directly to the physician. Notification of payment will also be sent to the insured.

EXCEPTION to the above agreement shall be as follows:

A participating member of the Foundation shall have the right and privilege of collecting from the patient up to his or her usual fee if the patient refuses to assign benefits of the program to the participating member. If the patient or his family has multiple coverage (by multiple coverage it is meant other insurance policies which will indemnify the insured for professional services regardless of payment made by Foundation endorsed programs), a participating member of the Foundation has the right and privilege to collect from the patient up to but not exceeding his or her usual fee.

It is the responsibility of the patient to make known at the initial visit the existence of other *possible* additional insurance benefits which may provide coverage. The total combined payment will in no instance exceed the amount charged for the service.

9. The Foundation for Medical Care in endorsing any program expects full cooperation by patients in the payment of co-insurance and deductibles of the contract and payment for the items which are not covered.

10. The Foundation for Medical Care will furnish a list of participating physicians to any member of a Foundation-endorsed health insurance plan. It is the responsibility of the patient, however, to ascertain in each instance whether or not a doctor is a participating member of the Foundation.

11. The Foundation shall not be responsible for delay in the performance of any agreement, nor for nonperformance of any agreement which is caused by, in whole or part, the failure of either the underwriting In-

surance Company, the employer, or the patient to furnish any required information promptly. If it should be necessary for the Foundation to repeat any services because of incorrect or incomplete data furnished by the underwriting company, the employer or the patient, an additional fee for such service may be charged. Foundation shall be entitled to rely on the information so provided as to accuracy and completeness and shall have no duty or responsibility to verify such information once supplied by the underwriting Insurance Company or the employer.

II. *STANDARDS FOR BASIC GROUP INSURANCE PROGRAMS MEDICAL COVERAGE — REQUIRED*

* * *

III. *STANDARDS FOR MAJOR MEDICAL GROUP INSURANCE PROGRAMS (i.e., SUPPLEMENTAL MAJOR MEDICAL OR TO BE USED WITH BASE PLANS AS A SUPER-IMPOSED MAJOR MEDICAL)*

* * *

IV. *STANDARDS FOR COMPREHENSIVE MAJOR MEDICAL INSURANCE PROGRAMS*

(Coverage may not be inconsistent with required Basic Plan minimums.)

* * *

V. *MODIFICATIONS*

1. Any deviations from the Foundation Standards for any group must be approved in writing by the Board of Trustees of the Maricopa Foundation for Medical Care.

VI. *RECOMMENDED ADDITIONAL COVERAGE — NOT REQUIRED*

* * *

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MEDICINE

GENERAL INFORMATION AND INSTRUCTION

1. The following visits, examinations, consultations and similar services are the most frequently recurring and widely variable items of medical care. The time requirements of these services range from the briefest possible contact with the patient to the time-consuming interview and exhaustive examination needed to appraise a complex medical problem.

The following gradation of services is listed in an attempt to reflect the relative values of the various times and skills required. These services may be employed for care of illness or health supervision.

Health supervision does not involve as a primary purpose the diagnosis and treatment of illness. Its purposes include an appraisal of the individuality and developmental level of the patient and the promotion of optimal health and personality growth as well as the prevention of illness. These services are included in items 9000 through 9030 in accordance with time and complexity of the services rendered. (See 9050, *et seq.*, for psychiatric services.)

2. "Sv." Items: "Sv." in the value column indicates the value is to be calculated as the sum of the various services rendered, (e.g., office, home, nursing home or hospital visit, consultation or detention, etc.) according to the ground rules covering those services.

3. Medical care of an unusual or unlisted value may occur which represents a type of service over and beyond listed procedures. If substantiated "By Report" (See Rule 5), additional unit values may be warranted.

4. "By Report": When the value of a procedure is to be determined "By Report", information concerning

the nature, extent and need for the procedure or service, the time, the skill, and the equipment necessary, etc., is to be furnished. A detailed clinical record is NOT necessary.

5. "INDEPENDENT PROCEDURE": Certain of the listed procedures are commonly carried out as an integral part of a total service, and as such do not warrant a separate charge. When such a procedure is carried out as a separate entity, not immediately related to other services, the indicated value for "Independent procedure" is applicable.

6. Values for mileage, night calls, preparation of special reports, etc., are listed under "Other Services" in this section (Items 9070–9075).

7. Necessary drugs, supplies and materials provided by the physician may be charged for separately.

8. Values for other diagnostic, therapeutic, surgical, anesthesia, x-ray and laboratory procedures are listed in the sections entitled "Surgery," "Anesthesia," "Radiology," and "Laboratory."

MEDICINE

OFFICE VISITS

Those services performed by a physician in his own office, or in an out-patient facility of a hospital, such as an out-patient clinic, examining or treatment room, etc. See 90500–90570 for emergency care.

NEW PATIENT

90000	Brief evaluation, history, examination and/or treatment	$27.00
90010	Initial limited history and examination, including initiation of diagnostic and treatment program	45.00

90015	Initial intermediate history and examination, including initiation of diagnostic and treatment program	60.00
90020	Initial comprehensive history and examination, including initiation of diagnostic and treatment program	80.00
	ESTABLISHED PATIENT	
90030	Minimal service — injection, minimal dressing, blood pressure or weight check	13.00
90040	Brief examination, evaluation and/or treatment	18.00
90050	Limited examination, evaluation and/or treatment	23.00
90060	Intermediate examination, evaluation and/or treatment	30.00
90070	Extended re-examination and/or re-evaluation	40.00
90080	Comprehensive re-examination and/or re-evaluation	60.00
90085	Comprehensive re-examination or re-evaluation when complicated by chronically disabling condition	72.00
	HOME VISITS	
90110	Initial limited history and examination, including initiation of diagnostic and treatment program	50.00
90115	Initial intermediate history and examination, including initiation of diagnostic and treatment program	50.00

90120	Initial comprehensive history and examination including initiation of diagnostic and treatment program	50.00

HOME VISITS; HOSPITAL VISITS; CRITICAL CARE SERVICES

ESTABLISHED PATIENT

90130	Minimal service, e.g., injection, immunization, minimal dressing, etc.	40.00
90140	Brief examination, evaluation and/or treatment, same or new illness	40.00
90150	Limited examination, evaluation, and/or treatment, same or new illness	40.00
90160	Intermediate examination, evaluation and/or treatment, same or new illness	40.00
90170	Extended re-examination or re-evaluation	40.00

(For examination, evaluation, and/or treatment, each additional resident member, use 90130)

HOSPITAL VISITS

NEW OR ESTABLISHED PATIENT
(For preoperative visits, see Surgery ground rule 1.)

90200	Initial hospital care, brief or limited history and examination, including initiation of diagnostic and treatment program and preparation of hospital records	45.00

* * *

Appendix B-14

ANESTHESIOLOGY

BASED ON THE 1973 AMERICAN SOCIETY OF ANESTHESIOLOGY RVG USING A $16.00 CONVERSION FACTOR.

A ONE UNIT MODIFIER IS ALLOWED FOR EMERGENCY CALLS AFTER 6:00 P.M.

SURGERY

GENERAL INFORMATION AND INSTRUCTIONS

1. Values for office, home and hospital visits, consultations and other medical services, x-ray and laboratory procedures are listed in the sections entitled "Medicine," "Anesthesia," "Radiology," and "Laboratory."

2. Listed values for all surgical procedures include the surgery and the follow-up care for the period indicated in days in the column headed "Follow-up Days." Necessary follow-up care beyond this listed period is to be added on a fee-for-service basis. Where the follow-up period is listed as zero (0) and the item is preceded by an asterisk (*), see (3) below.

3. ASTERISK (*): Where an asterisk (*) precedes a procedure number and its value, the following rules apply:

(a) The listed value is for the SURGICAL PROCEDURE ONLY.

(b) ALL POST-OPERATIVE CARE is to be ADDED on a fee-for-service basis.

(c) When such a procedure requires hospital admission, an additional two (2) units are to be added to the listed value to cover the additional services required. (Items 9020, 9021 or 9022 are not to be used in addition.)

(d) When such a procedure is carried out at the time of the initial visit, an additional one (1) unit is to be added to the listed value in lieu of item 9001, etc.

3. "Sv." ITEMS: "Sv." in the value column indicates that the value is to be calculated as the sum of the various services rendered (e.g., hospital visit, etc.) according to the ground rules covering those services.

4. "BY REPORT": When the value of a procedure is to be determined "by report," the following information may be required:

(a) Diagnosis (post-operative).
(b) Size, location and number of lesion(s) or procedure(s) where appropriate.
(c) Major surgical procedure and supplementary procedure(s).
(d) Whenever possible, list the nearest similar procedure by number according to these studies.
(e) Estimated follow-up period.
(f) Operative time.

COMPLICATIONS or other circumstances requiring additional and unusual services concurrent with the procedure(s) or during the listed period of normal follow-up care, may warrant additional charges on a fee-for-service basis.

When an additional surgical procedure(s) is carried out within the listed period of follow-up care for a previous surgery, the follow-up periods will continue concurrently to their normal terminations.

INDEPENDENT PROCEDURE: Certain of the listed procedures are commonly carried out as an integral part of a total service, and as such do not warrant a separate charge. When such a procedure is carried out as a *separate entity*, not immediately related to other ser-

vices, the indicated value for "Independent Procedure" is applicable.

MULTIPLE SURGICAL PROCEDURES:

(a) When multiple or bilateral surgical procedures, which add significant time or complexity to patient care, are performed at the same operative session, the total value shall be the value of the major procedure plus 50% of the value of the lesser procedure(s) unless otherwise specified in this Study.

(b) When an incidental procedure, (i.e., incidental appendectomy, lysis of adhesions, excision of previous scar, puncture of ovarian cyst) is performed through the same incision, the value will be that of the major procedure only.

PROCEDURES NOT SPECIFICALLY LISTED will be given values comparable to those of the listed procedures of closest similarity.

When warranted by the necessity of SUPPLEMENTAL SKILLS, values for services rendered by two or more physicians will be allowed.

When the SKILLS OF TWO SURGEONS are required in the management of a specific surgical procedure, by prior agreement, the total value may be apportioned in relation to the responsibility and work done, provided the patient is made aware of the fee distribution according to medical ethics. The value may be increased by 25 per cent under these circumstances.

1. INJECTION PROCEDURES in conjunction with radiological service(s) include necessary local anesthesia, placement of needle or catheter and injection of contract media. (See also Rule 7, page 53.)

1. NECESSARY DRUGS, materials and supplies *provided by the physician* may be charged for separately.

	SURGICAL ASSISTANTS	Value
80	Assist at surgery, 20% of listed unit value(s) of surgical procedure(s)	
81	minimum allowance	85.00

			Follow-Up Days
	INTEGUMENTARY SYSTEM		
	SKIN, MUCOUS MEMBRANE, AND SUBCUTANEOUS TISSUES		
	INCISION		
*10000	Incision and drainage of infected or non-infected sebaceous cyst, one lesion	12.00	0
10001	second lesion	6.00	
10002	over two, each additional lesion	4.00	
*10003	Incision and drainage of infected or non-infected epithelial inclusion cyst ("sebaceous cyst") with complete removal of sac and treatment of cavity	40.00	0
	(For excision, see 11400 et seq.)		
*10020	Incision and drainage of furuncle	12.00	0
*10040	Acne surgery (e.g., marsupialization, opening, or removal of multiple milia, comedones, cysts, pustules)	17.00	0
*10060	Incision and drainage of abscess (e.g., carbuncle, suppurative hidradentis and other cutaneous or subcutaneous abscesses), simple	21.00	0
*10080	Drainage of pilonidal cyst, simple	21.00	0

(For excision of pilonidal cyst, see 11770, 11771, 11772)

*10100	Drainage of onychia or paronychia	21.00 0
*10120	Incision and removal of foreign body, subcutaneous tissues, simple	21.00 0
*10140	Drainage of hematoma, simple	21.00 0
*10160	Puncture aspiration of abscess, hematoma, or cyst	12.00 0

EXCISION

DEBRIDEMENT

(For dermabrasions, see 15780–15800)

(For nail debridement, see 11700–11711)

(For burn(s), see 16000–16030)

DEBRIDEMENT (cont.)

*11000	Debridement of extensively eczematous or infected skin up to 10% of the body surface	21.00 0
11001	for each additional 10% of the body surface	8.00
11040	Debridement of abrasions	17.00 0

PARING OR CURETTEMENT

*11050	Paring or curettement of a benign lesion with or without chemical cauterization (such as verrucae or clavi), single lesion	21.00 0
11051	each additional four or less	8.00
11052	all additional lesions	8.00

EXCISION AND SIMPLE CLOSURE

(Not reconstructive surgery; for reconstructive surgery, see "Repair-Complex")

11100	Biopsy of skin or subcutaneous tissue (including simple closure), unless otherwise listed (independent procedure)	34.00 7
11101	each additional lesion	17.00

* * *

RADIOLOGY

X-RAY — DIAGNOSTIC

GENERAL INFORMATION AND INSTRUCTIONS

1. Values include usual contrast media, equipment and materials. An additional charge may be warranted when special surgical trays and materials are provided by the physician.

2. Values include consultation and written report to the referring physician.

3. When x-ray examinations are made in conjunction with other medical services at the same visit, and by the same physician, values for each x-ray examination will be reduced by 0.5 units unless otherwise specified.

4. When multiple x-ray examinations are made at the same visit and without concomitant other services, values for each examination except the major examination will be reduced 0.5 units unless otherwise specified in this Study.

5. When progress examinations of the same part and for the same illness are made within twenty-four (24) hours, the value of the secondary examination will be reduced by 0.5 units, unless otherwise specified in this Study.

6. Values for bedside, home or operating room examinations (unless otherwise indicated) are listed under Miscellaneous Studies, 7476 and 7477.

7. For procedures marked by a small black star (*), the injection procedure (i.e., necessary local anesthesia, placement of needle or catheter and injection of contrast media) is *not* included in the unit value. For procedures not marked with a small black star(*) the injection procedure by the radiologist is included in the unit value.

DIAGNOSTIC RADIOLOGY

		PC	TOTAL
	HEAD AND NECK		
70002	Pneumoencephalography, supervision and interpretation only	69.30	177.30
70003	complete procedure	189.00	295.50
70010	Myelography, posterior fossa, supervision and interpretation only	63.00	147.75
70011	complete procedure	119.70	206.85
70015	Cisternography, positive contrast, supervision and interpretation only	63.00	147.75
70016	complete procedure	119.70	206.85
70020	Ventriculography, air contrast, supervision and interpretation only	59.00	133.85
70021	positive contrast, supervision and interpretation only	59.00	133.85

70022	Stereotactic localization, head	81.90	177.30
70030	Eye, for foreign body	16.80	39.40
70040	for localization of foreign body (70030 not included)	33.60	68.95
70050	combined 70030 and 70040	42.00	88.65
70100	Mandible, partial, less than four views	12.60	29.55
70110	complete, minimum of four views	21.00	49.25
70120	Mastoids, less than three views per side	16.80	39.40
70130	complete, minimum of three views	25.20	59.10
70134	Internal auditory meati, complete	25.20	59.10
70140	Facial bones, less than three views	12.60	29.55
70150	complete, minimum of three views	21.00	49.25
70160	Nasal bones, complete, minimum of three views	12.60	29.55
70170	Nasolacrimal duct (dacryocystography) supervision and interpretation only	16.80	39.40
70171	complete procedure	48.30	68.95
70190	Optic Foramina	12.60	29.55
70200	Orbits, complete, minimum of four views	21.00	49.25
70210	Sinuses, paranasal, less than three views	12.60	29.55

70220	complete, minimum of three views	21.00	49.55
70230	contrast studies, in addition to 70220, supervision and interpretation only	18.90	49.55
70231	contrast studies, in addition to 70220, complete procedure	100.80	118.20
70240	Sella Turcica	16.80	39.40
70250	Skull, less than four views, with or without stereo	12.60	29.55
70260	complete, minimum of four views, with or without stereo	21.00	49.25

* * *

PATHOLOGY GROUND RULES

GENERAL INFORMATION AND INSTRUCTIONS

1. UNUSUAL SERVICE OR PROCEDURE: A service may necessitate skills and time of the physician over and above listed services and values. If substantial "by report" additional values may be warranted. (See modifier — 22)

2. UNLISTED SERVICE OR PROCEDURE: Identify as 99200. When an unlisted service or procedure is provided, the values used should be substantiated "by report." (See rule 4 below.)

3. BY REPORT ("BR") ITEMS: BR in the value column indicates that the value of this service is to be determined "by report," because the service is too unusual, variable or new to be assigned a unit value. Pertinent information concerning the nature, extent and need for the procedure or service, the time, the skill and equip-

ment necessary, etc., is to be furnished. A detailed clinical record is not necessary.

4. MATERIALS SUPPLIED BY PHYSICIAN: Identify as 99070. Supplies and materials provided by the physician (e.g., sterile trays, drugs, etc.) over and above those usually included with the office visit or other services rendered may be charged for separately. (List drugs, trays, materials or supplies provided.)

5. PANEL (PROFILE) TESTS: Panel (profile) tests are defined as certain multiple tests performed on a single specimen of blood or urine. They are distinguished from the single or multiple tests performed on an "individual," "immediate" or "stat" reporting basis.

6. MISCELLANEOUS: Values for office, home, and hospital visits, consultations and other medical services, X-ray, anesthesia and surgical procedures are listed in the sections entitled MEDICINE, ANESTHESIA, SURGERY and RADIOLOGY and NUCLEAR MEDICINE.

Automated, Multichannel Tests; Urinalysis; Chemistry & Toxicology

PATHOLOGY

AUTOMATED, MULTICHANNEL TESTS

The following list contains those tests which can be and are frequently done as groups and combinations on automated multichannel equipment. The unit values apply when three or more of these tests are ordered per patient visit. For reporting two tests, regardless of method of testing, use appropriate single test code numbers. Collection and handling is not included.

Albumin
Bilirubin, direct

Bilirubin, total
Calcium
Carbon dioxide content
Chlorides
Cholesterol
Creatinine
Globulin
Glucose (sugar)
Lactic dehydrogenase
Phosphatase, alkaline
Phosphorus
Potassium
Protein, total
Sodium
Transaminase, glutamic oxalacetic (SGOT)
Transaminase, glutamic pyruvic (SGPT)
Urea nitrogen
Uric acid

80104	Any three or four tests	15.00
80105	Any five tests	15.75
80106	Any six tests	16.50
80112	Any seven through twelve tests	19.50
80116	Any thirteen through sixteen tests	22.50
80118	Any seventeen or eighteen tests	25.50
80119	Over eighteen tests (indicate instrument used and number of tests performed)	RNE[degrees]

URINALYSIS

(For specific analyses, see appropriate section)

81000 (When combined with CBC, see 89005–89007 for reporting)

81000	Urinalysis, routine, complete (chemical and microscopic)	6.00
81005	chemical, qualitative, any number of constituents	4.00
81010	concentration and dilution test	7.00
81015	microscopic only	4.00
81016	microscopic when done in conjunction with 81005	2.00
81020	two or three glass test	7.00
81030	Quantitative sediment analysis and quantitative protein (Addis count)	12.00
81099	Unlisted urinalysis procedure	BR

CHEMISTRY AND TOXICOLOGY

Material for examination from any source, quantitative unless specified.

(APT test, see 83033)

(Acetaldehyde, blood, see volatiles 84600)

82003	Acetaminophen (Tylenol), urine	37.50

(Acetic anhydride, see volatiles, 84600)

82005	Acetoacetic acid	21.25
82009	Acetone, qualitative	6.00
82010	quantitative	17.00

* * *

APPENDIX C

Comparisons of Changes in Average Conversion Factors and Consumer Price Indices

	Average Conversion Factor: Maricopa Foundation	National Consumer Price Index for "Physicians' Services"[4]	National Index for "Medical Care"[4]
1978	10.40[1]	223.1	219.4
1973	7.62[2]	138.2	137.7
Difference	2.78	84.9	81.7
Average Annual Change	7.3%	12.3%	11.9%
1978	10.40	223.1	219.4
1970	6.63[3]	121.4	120.6
Difference	3.77	101.7	98.8
Average Annual Change	7.1%	10.5%	10.2%

[1]J.A. 268 ¶ 304.

[2]J.A. 211 ¶ 94.

[3]J.A. 210 ¶ 93.

[4]United States Bureau of the Census, *Statistical Abstract of the United States: 1980* (1981) at 486-87 (1967 = "100").

[5]Hogan & Armstrong, *Consumer Prices: A Record Increase in 1980*, 28 Ariz. Bus. (March 1981) 3 at 10-11 (1969 = "100").

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National Index for "All Items"[4]	Metropolitan Phoenix Index for "All Items"[5]	Metropolitan Phoenix Index for "Medical Care"[5]
195.4	171.0	179.5
133.1	120.8	165.2
62.3	50.2	14.3
9.4%	8.3%	1.7%
195.4	171.0	179.5
116.3	104.2	133.2
79.1	66.8	46.3
8.5%	8.0%	4.3%

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In the Supreme Court
OF THE
United States

OCTOBER TERM, 1981

STATE OF ARIZONA,
PETITIONER,

vs.

MARICOPA COUNTY MEDICAL SOCIETY,
MARICOPA FOUNDATION FOR MEDICAL CARE, AND
PIMA FOUNDATION FOR MEDICAL CARE,
RESPONDENTS.

ON WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE NINTH CIRCUIT

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Abbreviations:

American Hospital Association Brief *Amicus Curiae* .... AHA Br.

Brief for Petitioner ..... Pet. Br.

California Dental Service Brief *Amicus Curiae* ..... CDS Br.

Clerk's Record ..... C.R.

Joint Appendix ..... J.A.

Joint Brief in Opposition ..... Br. Opp.

Joint Brief for Respondents ..... Resp. Br.

Petition for a Writ of Certiorari ..... Pet.

Reply Memorandum for Petitioner ..... Reply

No. 80-419

In the Supreme Court
OF THE
United States

OCTOBER TERM, 1981

STATE OF ARIZONA,
PETITIONER,

v.

MARICOPA COUNTY MEDICAL SOCIETY,
MARICOPA FOUNDATION FOR MEDICAL CARE, AND
PIMA FOUNDATION FOR MEDICAL CARE,
RESPONDENTS.

ON WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE NINTH CIRCUIT

REPLY BRIEF FOR PETITIONER

SUMMARY OF ARGUMENT

Respondents' defense of their agreed-upon fee schedules is predicated upon a series of misconceptions of basic antitrust principles. They equate the unilateral decision of a single actor in the marketplace with an agreement among an association of competitors; they seem to view vertical restraints as more egregious violations than agreements among horizontal competitors; and they overlook or ignore the critical characteristics distinguishing the two complementary categories of antitrust analysis — economic integration and ancillarity. Respondents' treatment of summary judgment procedures is no better. Having failed to identify even a single issue of material fact requiring a trial, they parade a series of irrelevant and immaterial disputes while simultaneously proclaiming that this case

is now moot because they have adopted a new fee schedule.[1] The only possible arguments for avoiding *per se* illegality — economic integration and ancillarity — have not even been mentioned by respondents nor could they be since the undisputed facts conclusively negate the existence of any facts to support them.

ARGUMENT

I. ANY FEE SCHEDULE AGREED UPON BY COMPETITORS IS A *PER SE* VIOLATION EVEN IF IT IS CALLED A MAXIMUM SCHEDULE

The facts necessary for this Court's decision are clear and undisputed. Respondents' own by-laws provide for the preparation and use of "uniform, average or median fee schedules." C.R. 19, Ex. 1, at 2-3. Respondents' fee schedules have, in fact, served this function. *See* Pet., at 3-5; Reply Apps. A-C; Pet. Br., at 2-12. Thus, respondents concede that they have established their fee schedules at levels above the average fees computed in price surveys and that following adoption of new schedules 85 to 95 percent of their members charged prices equal to or above those adopted. *See* Pet. Br., at 7 n.7. Despite these admitted facts, respondents persist in arguing that they only set the maximum fees their members receive under foundation-endorsed pre-paid health plans.[2] Even under their own characterization of the facts, however, respondents'

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[1]Respondents' claim of mootness is without merit. The competing physicians have done no more than select an agent for formulating their fee schedules which in itself is unlawful, *see, e.g., United States v. New Wrinkle, Inc.*, 342 U.S. 371 (1952); *United States v. Masonite Corp.*, 316 U.S. 265 (1942); and certainly places the case within the category of conduct "capable of repetition, yet evading review." *E.g., Dunn v. Blumstein*, 405 U.S. 300, 333 n.2 (1972). In any event, the present case seeks declaratory as well as injunctive relief, J.A. 1, 11, which, by itself, keeps it from becoming moot. *Super Tire Engineering Co. v. McCorkle*, 416 U.S. 115 (1974).

[2]Resp. Br., at 15. Under respondents' theory, they hold prices down in order to stave off competition from health maintenance organizations, but this is no defense since "a combination or conspiracy to fix and control prices . . . [to exclude] any attempted intrusion by competitors" is itself unlawful. *American Tobacco Co. v. United States*, 328 U.S. 781, 800 (1946).

conduct is unlawful because any adoption of a fee schedule by competitors is a *per se* violation.[3]

It has long been recognized that "[u]nder the Sherman Act a combination formed for the purpose and with the effect of raising, depressing, fixing, pegging, or stabilizing the price of a commodity in interstate or foreign commerce is illegal *per se*." *United States v. Socony-Vacuum Oil Co.*, 310 U.S. 150, 223 (1940). *Accord United States v. McKesson and Robbins, Inc.*, 351 U.S. 305, 310 (1956) ("It makes no difference whether . . . the agreement is to raise or to decrease prices."). In *Kiefer-Stewart Co. v. Joseph E. Seagram & Sons, Inc.*, 340 U.S. 211, 213 (1951), this Court applied *Socony* and held that "agreement[s] among competitors to fix maximum . . . prices of their products . . .no less than those to fix minimum prices . . . [are] illegal *per se*." *Accord Albrecht v. Herald Co.*, 390 U.S. 145 (1968). The other Courts of Appeals considering

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[3]To be sure, the *Goldfarb* Court did intimate that a "purely advisory fee schedule issued to provide guidelines" might not present the same question of *per se* illegality. *Goldfarb v. Virginia State Bar*, 421 U.S. 773, 781 (1975). It is respectfully submitted that this statement was an unfortunate *obiter dictum* which should now be corrected by this Court. This Court should hold that any fee schedule adopted by a group of competitors -- even if it is claimed to be purely advisory -- is *per se* unlawful. *See United States v. National Association of Real Estate Boards, supra*, 339 U.S., at 713-14, 717 (1950); *United States v. Nationwide Trailer Rental System, Inc.*, 156 F. Supp. 800, 805 (D. Kan. 1955), *aff'd*, 355 U.S. 10 (1957).

It is extremely improbable if not inconceivable that a group of competitors would ever adopt a fee schedule that was not intended to influence future prices. Why, after all, would a group of competitors expend the effort of preparing a fee schedule and risk a close brush with illegality if the fee schedule were not intended to have some prospective effect on prices? And, of course, if it were adopted for the purpose of influencing prices it would be *per se* unlawful even if the competitors did not have the power to implement their agreement. *United States v. Socony-Vacuum Oil Co.*, 310 U.S. 150, 224 n.59 (1940). Since part of the rationale of the *per se* rule is the judicial efficiency in "avoid[ing] the necessity for an incredibly complicated and prolonged economic investigation into the entire history of the industry involved," *Northern Pacific R. Co. v. United States*, 356 U.S. 1, 5 (1958), even so-called "advisory fee schedules" should be held to be *per se* unlawful so that the courts can be spared "an incredibly complicated and prolonged economic investigation" in the hope of proving the implausible fact that the advisory fee schedules were not intended to have any effect.

this issue have followed *Kiefer-Stewart* and held horizontal maximum price-fixing *per se* unlawful. *See* Pet., at 13 n.31. The lower courts did not follow these precedents, however.[4]

Respondents no longer try to defend the rationale of either of the lower courts, *compare* Resp. Br., at 40-45, *with* Br. Opp., at 21-22, but instead argue that *Kiefer-Stewart* and *Albrecht* either were overruled or sharply limited by *Continental T.V., Inc. v. GTE Sylvania, Inc.*, 433 U.S. 36 (1977), *see* Resp. Br., at 42-43, and then suggest that an agreement among competing sellers on how much they will receive should be treated the same as a single purchaser's unilateral decision of how much it will pay. *Id.*, at 44 n.122. As for respondents' argument that *Continental T.V.* makes *Kiefer-Stewart* and *Albrecht* "suspect," Resp. Br., at 41, suffice it to say that this Court has recently cited and followed those precedents in *California Retail Liquor Dealers Association v. Midcal Aluminum, Inc.*, 445 U.S. 97, 102, 103, 109 (1980), and they therefore retain their vitality. Respondents' further attempt to limit *Kiefer-Stewart* and *Albrecht* is based on their apparent belief that vertically-imposed restraints of trade are more egregious than horizontal ones, Resp. Br., at 45, but this argument is supported only by a citation to *Continental T.V.*, which actually stands for the opposite proposition. In *Continental T.V.*, after all, this Court applied the Rule of Reason to a vertically-imposed territorial allocation while recognizing the continued applicability of the *per se* rule to horizontal territorial divisions. *See* 433 U.S., at 57 n.27, *citing*

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[4]Relying on *Continental T.V., Inc. v. GTE Sylvania, Inc.*, 433 U.S. 36 (1977), the District Court declined to follow *Kiefer-Stewart* because it perceived "a recent antitrust trend . . . where the Rule of Reason [rather than the *per se* rule] is the preferred method of determining whether a particular practice is in violation of the antitrust law," Pet. App. D, at 43, but the recent decisions in *Catalano, Inc. v. Target Sales, Inc.*, 446 U.S. 643 (1980), and *National Society of Professional Engineers v. United States*, 435 U.S. 679 (1978), belie any such retreat from the *per se* rule. The Ninth Circuit was more blunt and said simply, "This circuit has not extended [*Kiefer-Stewart* and *Albrecht*] to horizontal agreements that establish maximum prices," 643 F.2d, at 557 n.4, but this ignores the fact that the agreement in *Kiefer-Stewart* was horizontal. Interestingly, the only authority which the Ninth Circuit cited in connection with its peculiar conclusion was one which argued that horizontal maximum price-fixing was *per se* unlawful. L. Sullivan, Antitrust 210 (1977), *cited at* 643 F.2d, 557 n.4.

United States v. Topco Associates, Inc., 405 U.S. 596, at 608 (1972).

The gravamen of respondents' defense of their maximum price-fixing scheme therefore comes down to a fundamental misconception of the antitrust laws equating the unilateral action of a single participant in the marketplace with an agreement among competitors establishing and using a price list. Respondents criticize the State of Arizona, for example, for establishing the maximum amounts it will pay in certain governmentally-funded health plans[5] and on that basis complain that "[p]etitioner itself was shown to engage in the very conduct it seeks to enjoin." Resp. Br., at 23. To the same effect, respondents perceive some inconsistency between the Department of Justice's approval in *Group Life & Health Insurance Co. v. Royal Drug Co.*, 440 U.S. 205 (1979), of a third-party payor's unilateral decision establishing how much it would pay and its condemnation here of an agreement among competitors on how much they would receive.[6]

That respondents even advance this argument evidences a fundamental ignorance of the essence of a section 1 violation. Section 1 of the Sherman Act, 15 U.S.C. § 1, prohibits a "contract, combination . . . or conspiracy in restraint of trade." Under either the *per se* rule or the Rule of Reason, what is unlawful is the agreement. A single trader may lawfully decide how much it will pay or how

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[5]Resp. Br., at 14, 22-23. The State of Arizona has established maximum fee schedules for the amounts it will pay to physicians under its workmen's compensation program and its medical and dental program for foster children. J.A. 472-74. Respondents note that for some services the State provides for "higher maximum reimbursement levels than respondents," Resp. Br., at 22, but this is of no moment. It may well be, for example, that the State of Arizona has decided to set maximum levels at a sufficiently high level in order to maximize the number of physicians who will treat foster children or injured workmen but this is no justification for a group of competitors to agree upon a sufficiently high level of payment necessary to satisfy a majority of their members.

[6]Resp. Br., at 44 n.122. The California Dental Service as amicus curiae also seems to have overlooked the important distinction recognized by the Department of Justice. From all that appears in its brief and the reported decision, *Manasen v. California Dental Service*, 1981-1 CCH Trade Cas. ¶ 63,959 (N.D. Cal. 1980), the California Dental Service is simply an independent third-party payor and is not a combination of competitors.

little it will accept even though an agreement among competitors to accomplish the same end would be unlawful. *American Tobacco Co. v. United States*, 328 U.S. 781 (1946). *See also, e.g., National Society of Professional Engineers v. United States, supra*, 435 U.S., at 695 n.21 ("[T]he reasonableness of an individual purchaser's decision not to seek lower prices through competition does not authorize the vendors to conspire to impose that same decision on all other purchasers."). Respondents cannot defend their agreement on the theory that a single trader could lawfully adopt the same practice.

II. THERE IS NOTHING ABOUT THE HEALTH CARE INDUSTRY IN GENERAL OR RESPONDENTS' PARTICULAR ACTIVITIES WHICH JUSTIFY EXEMPTING THEIR AGREED-UPON FEE SCHEDULES FROM NORMAL *PER SE* ANALYSIS.

A. *Because There Is No Economic Integration and Because Their Anticompetitive Agreements Are Not Necessary and Ancillary to a Lawful Purpose There Is Nothing in Respondents' Activities Which Creates a Genuine Issue for Trial*

In trying to defend their fee schedules by saying they create "a uniquely desirable product which could not exist unless the foundations themselves establish the maximum levels of reimbursement to be paid," Resp. Br., at 23, respondents either misconprehend or ignore fundamental tenets of the Rule of Reason and the *per se* rule which date back to Judge Taft's seminal opinion in *United States v. Addyston Pipe & Steel Co.*, 85 F. 271 (6th Cir. 1898), *aff'd*, 175 U.S. 211 (1899), *discussed in National Society of Professional Engineers v. United States, supra*, 435 U.S., at 688-92. In his classic analysis distinguishing restraints of trade unlawful on their face and those merely ancillary to lawful contracts, Judge Taft identified economic integration as one of the necessary prerequisites to any escape from the *per se* rule. 85 F., at 280-83. Thus, "when two men become partners in a business, although their union might reduce competition," the partnership would be lawful because the reduction in competition "was only an incident to the main purpose of a union of their capital, enterprise, and energy to carry on a successful business." *Id.*, at 280. Absent this "union of

. . . capital, enterprise and energy" — absent this economic integration — any agreement between the two men reducing competition between them would be unlawful on its face. *Id.*, at 282-83. *See also* R. Bork, The Antitrust Paradox at 268-69 (1978). Those who wish to avoid the application of the *per se* rule to an agreement which restrains trade must therefore show that the restraint is merely ancillary to an otherwise lawful integration of economic resources.

The necessity of showing economic integration as a precondition of avoiding the *per se* rule has been recognized and preserved in later cases including *Continental T.V.* and *Broadcast Music, Inc. v. Columbia Broadcasting System*, 441 U.S. 1 (1978), upon which respondents place such great reliance. *Continental T.V.* dealt with the question of intrabrand competition where consideration had to be given to "efficiencies in the distribution of [the manufacturer's] products," 433 U.S., at 54, and where there was an integration or joint undertaking by the manufacturer and the retailer in the sale of a single product. The licensing agreement in *Broadcast Music* was also part of an extensive economic integration which "accompanie[d] the integration of sales, monitoring, and enforcement against unauthorized copyright use." 441 U.S., at 20. The significance of economic integration was further emphasized in *Broadcast Music* by reference to mergers and joint ventures as two examples where agreements eliminating price competition between competitors would not necessarily be *per se* violations of the antitrust laws. *Id.*, at 23. In both of these examples there would be economic integration — a combination or pooling of productive assets — and it would be this economic integration which would take them out of the *per se* rule. *See also National Society of Professional Engineers v. United States, supra*, 435 U.S., at 688-89.

The medical profession provides a ready supply of specific examples in the same vein as those mentioned in *Broadcast Music*. When two physicians enter a partnership, for example, their agreement precisely fits Judge Taft's classic paradigm and because of the economic integration of productive assets and the sharing of economic risks and benefits their partnership would not be a *per se* violation even though it eliminated competition between them. To the same effect are health maintenance organizations (HMOs), *see* 42 U.S.C.§ 300e *et seq.*, where a group of health care providers combine to furnish integrated and coordinated medical services in

return for fixed pre-paid fees and where the providers bear the economic risk of success or failure of their joint enterprise. Though an HMO may eliminate competition among the participating providers, it should be beyond the scope of the *per se* rule because of the economic integration necessary for the operation of an HMO.

Respondents are far removed from these situations. There is neither integration of productive assets nor any sharing of economic risks and benefits and respondents have not suggested otherwise.[7] Quite to the contrary, respondents readily admit their differences from closed-panel or economically integrated pre-paid medical plans. *See* Resp. Br., at 29. Respondents' members are all independently practicing physicians — there is no pooling of their productive assets. Nor do respondents' members share the prospects of any economic risks or benefits from their joint enterprise — each member is guaranteed the payment prescribed by the foundations' fee schedules and any actuarial risk is borne entirely by third-party payors. J.A. 35. Since their activities are totally devoid of any economic integration, respondents fail to satisfy the most basic requirement for exempting their conduct from the *per se* rule.

Respondents nonetheless seek to avoid their lack of economic integration by suggesting that their fee schedules are necessary for the accomplishment of some other lawful purpose but this argument is without merit. Aside from their establishment of fee schedules, the only other functions that the respondents have ever claimed that they perform are acting "as the agents of participating insurers or self-insured groups" and of performing peer "review [of] the medical necessity and propriety of treatment rendered." Resp. Br., at 8-9. Neither of these functions require that the respondents establish fee schedules, 643 F.2d, at 555, nor has the legality of these two

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[7]Respondents' failure — and, indeed, their inability — to come forward with any justification for their fee schedules has not been missed by the commentators. Considering the Ninth Circuit opinion in this case, for example, Professor Wesley J. Liebeler has written, "While it is certainly desirable to exercise caution in finding new types of arrangements to be illegal *per se*, it is not too much to ask that the defendant come forward with some plausible explanation of how the elimination of competition furthers some legitimate end of the underlying integration. The fact that this was not done in this case is not particularly surprising: there does not appear to be any such explanation." W. Liebeler, *Antitrust Advisor* at 14 (2d ed. 1980 Cum. Supp.).

functions ever been challenged by this suit. Respondents readily admit that they can and do function as insurance administrators or "agents of participating insurers or self-insured groups" without themselves establishing fee schedules. *See, e.g.*, Resp. Br., at 22 n.70; J.A. 405-27. To the same effect, utilization review can and is performed without the need for competitors to agree upon a fee schedule. J.A. 409-22. Respondents' final contention that competitors "themselves [must] establish the maximum levels of reimbursement to be paid" for an effective pre-paid health plan, Resp. Br., at 23, quite simply is demonstratably false. *See, e.g., Group Life & Health Ins. Co. v. Royal Drug Co., supra.*

B. *There Is Nothing about the Health Care Industry Which Requires a Trial of the Issue Whether Doctors' Fee Schedules Are Exempt from Normal Antitrust Rules*

Aside from saying over and again that "the challenged conduct in this action concerns pricing in the medical profession," *e.g.*, Resp. Br., at 29, respondents fail to identify a single specific reason why doctors may agree upon fee schedules but other professional groups may not.[8] A party opposing summary judgment has the burden of at least identifying specific material facts which present a genuine issue for trial[9] but respondents have neither addressed nor met that minimal burden.

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[8]Respondents have failed to mention so much as a single characteristic of doctors which distinguish them from lawyers, *Goldfarb v. Virginia State Bar*, 421 U.S. 773 (1975); realtors, *United States v. National Association of Real Estate Boards*, 339 U.S. 485 (1950); pharmacists, *United States v. Utah Pharmaceutical Association*, 371 U.S. 24, *aff'g*, 201 F. Supp. 29 (D. Utah 1962); or accountants, *United States v. Texas State Board of Public Accounting*, 464 F. Supp. 400 (W.D. Tex. 1978), *aff'd*, 592 F.2d 919 (5th Cir.), *cert. denied*, 444 U.S. 925 (1979).

[9]Rule 56(e), Federal Rules of Civil Procedure, provides: "When a motion for summary judgment is made . . ., an adverse party may not rest upon the mere . . . denials of his pleading, but his response . . . must set forth specific facts showing that there is a genuine issue for trial. If he does not so respond, summary judgment, if appropriate, shall be entered against him." Rule 56(f), Federal Rules of Civil Procedure, is an alternative means by which a party opposing a summary judgment motion can simply identify the "facts essential to justify his opposition" even though discovery has not yet been undertaken. At no stage of the proceedings have respondents made any attempt under either Rule 56(e) or 56(f) to identify any specific characteristics of the medical profession which present "a genuine issue for trial."

Rather than coming forward with any specific facts, respondents rely upon footnote 17 in *Goldfarb v. Virginia State Bar*, 421 U.S. 773, 788 n.17 (1975), where this Court said, "The fact that a restraint operates upon a profession as distinguished from a business is, of course, relevant in determining whether that particular restraint violates the Sherman Act."[10] Respondents read the *Goldfarb* footnote and the similar language in *Professional Engineers*, 435 U.S., at 686, much too broadly. It may well be that some restraints may receive more lenient antitrust treatment because they occur in "a profession as distinguished from a business" but that certainly does not support respondents' arguments that all restraints within the professions are necessarily treated more leniently or must always be decided at trial. Indeed, both *Goldfarb* and *Professional Engineers* rejected respondents' far-reaching arguments.

Goldfarb, like the present case, involved a fee schedule adopted by a professional association but, unlike this case, those defendants at least offered specific reasons why their conduct should be judged by different antitrust standards than those applied to other sectors of the economy. This Court held that the fee schedule was "a classic illustration of price-fixing," 421 U.S., at 783, and re-

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[10]*Quoted in* Resp. Br., at 34-35. Respondents overlook the fact that this footnote was a qualification of this Court's textual statement that "the exchange of . . . a service for money is 'commerce' in the most common usage of that word." 421 U.S., at 788. Here, as in *Goldfarb*, we deal simply with the exchange of a service for money which is commerce in the most ordinary sense and the considerations acknowledged by footnote 17 do not apply.

Respondents also rely upon *Boddicker v. Arizona State Dental Association*, 549 F.2d 626, 632 (9th Cir.), *cert. denied*, 434 U.S. 825 (1977), where the Ninth Circuit said that "to survive a Sherman Act challenge a particular practice, rule, or regulation of a profession . . . must serve the purpose for which the profession exists, *viz.* to serve the public." Since *Boddicker* was decided prior to *Professional Engineers* which rejected its rationale, respondents' reliance on *Boddicker* is misplaced. Respondents also cite *Veizaga v. National Board for Respiratory Therapy*, 1977-1 CCH Trade Cas. ¶ 61,274 (N.D. Ill. 1977), for the proposition that "whether the questioned conduct was professional or commercial could not be made before trial," Resp. Br., at 29-30, but respondents ignore the fact that this Court has already decided that "the exchange of . . . a service for money is 'commerce' in the most common usage of that word." *Goldfarb v. Virginia State Bar*, *supra*, 421 U.S., at 788.

jected the arguments for an exception: "The nature of an occupation, standing alone, does not provide sanctuary from the Sherman Act, nor is the public-service aspect of professional practice controlling in determining whether § 1 includes professions." *Id.*, at 787 (citations omitted).

Professional Engineers was to the same effect. There, a professional association sought to justify its ban on competitive bidding because it was adopted "for the purpose of minimizing the risk that competition would produce inferior engineering work endangering the public safety." 435 U.S., at 681. This Court rejected the engineers' reliance on the *Goldfarb* footnote saying it "cannot be read as fashioning a broad exemption under the Rule of Reason for learned professions," *id.*, at 696, and held that there was no need to consider "the factual basis for the proffered justification before rejecting it . . . [b]ecause . . . the asserted defense rests on a fundamental misunderstanding of the Rule of Reason . . . ." *Id.*, at 681. Indeed, this Court explicitly rejected the very defense respondents would now raise: "The early cases also foreclose the argument that because of the special characteristics of a particular industry, monopolistic arrangements will better promote trade and commerce than competition." *Id.*, at 689. *Accord United States v. Socony-Vacuum Oil Co., supra,* 310 U.S., at 222 ("Whatever may be its peculiar problems and characteristics, the Sherman Act, so far as price-fixing agreements are concerned, establish one uniform rule to all industries alike.").

Respondents have not even gone so far as the defendants in *Goldfarb* and *Professional Engineers* where the defendants had at least offered specific justifications. Here, the respondents have offered no justification of any sort. Perhaps recognizing respondents' failure to satisfy their burden under Rules 56(e) and 56(f), the Ninth Circuit and the two amici have conjured up a list of supposedly unique characteristics of the health care industry which are suggested either to exempt this industry from normal antitrust rules or to make summary judgment inappropriate. None of these characteristics, however, is unique to the health care industry and, in any event, they have all been rejected by the courts.

Foremost among the supposed reasons for exempting the health care industry is the suggestion that this is a market "in which ordinary competitive forces necessarily operate in a weakened man-

ner." CDS Br., at 3. It may well be that the health care industry is less competitive than other sectors of the economy but that is no justification since "the special characteristics of a particular industry" cannot be an excuse for "monopolistic arrangements." *National Society of Professional Engineers v. United States, supra,* 435 U.S., at 689. Nor is it of any moment whether the anticompetitive character of the health care industry is the result of private agreement, governmental regulation,[11] or some combination of the two. That this industry may be tainted by other anticompetitive agreements is irrelevant: "[T]he fact that there may be somewhere in the background a greater conspiracy from which flow consequences more serious than we have here is no warrant for a refusal to deal with the lesser one which is before us." *United States v. Crescent Amusement Co.*, 323 U.S. 173, 188 (1944). Similarly, governmental regulatory action that may have contributed to the anticompetitive nature of the industry is no defense. Even where price-fixing schemes were the direct outgrowth of governmental regulatory programs, this Court has held them to be unlawful. *E.g., Federal Trade Commission v. Cement Institute,* 333 U.S. 683 (1948); *United States v. Socony-Vacuum Oil Co., supra.* "The Court has already decided that state authorization, approval, encouragement or participation in private anticompetitive conduct confers no antitrust immunity." *Cantor v. Detroit Edison Co.*, 428 U.S. 579, 592-93 (1976) (footnotes omitted). No weight should be given to the Ninth Circuit's argument that government regulation may have interfered with competitive forces since that argument does not even rise to the level of the defenses which have been repeatedly rejected by this Court. *E.g., National Gerimedical Hospital and Gerontology*

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[11]Thus, Judge Sneed lists "numerous government subventions of the costs of medical care [which] have created both a demand and supply function for medical services that is artificially high," 643 F.2d, at 556, as one of the reasons for denying summary judgment. To the same effect, the amici point to "the extent of government regulation," CDS Br., at 3; *see also* AHA Br., at 11, as a reason for denying relief. No one suggests, however, that respondents' fee schedules were in any way compelled by either the state or federal governments acting in their sovereign capacities, *see Parker v. Brown,* 307 U.S. 341 (1943), or that there is any express exemption from the antitrust law. *See National Gerimedical Hospital and Gerontology Center v. Blue Cross,* ____ U.S. ____, 101 S. Ct. 2415 (1981).

Center Blue Cross, ___ U.S. ___, 101 S. Ct. 2415 (1981); *Cantor v. Detroit Edison, supra*; *United States v. Philadelphia National Bank*, 374 U.S. 321 (1963); *United States v. Trans-Missouri Freight Association*, 166 U.S. 290 (1897).

It has also been suggested that "the third-party payment mechanism," AHA Br., at 2, and "the prevalence of third-party payers," CDS Br., at 3, somehow distinguish the medical profession from other sectors of the economy therefore requiring a different antitrust standard. This is but another variant of the consistently-rejected theme "that because of the special characteristics of a particular industry, monopolistic arrangements will better promote trade and commerce than competition." *National Society of Professional Engineers v. United States, supra*, 435 U.S., at 681. In any event, third-party reimbursement may be used to compensate lawyers, automobile body repair shops and the like, *cf. Group Life & Health Ins. Co. v. Royal Drug Co., supra*, 440 U.S., at 232 n.40, and it cannot be suggested that those businesses are exempted from antitrust scrutiny by the presence of third-party payors. If anything, the third-party payment mechanism is a reason for allowing maximums to be set by a third-party payor rather than a cartel.

It has also been suggested that "the high degree of technological complexity involved," "patient naivete with respect to differences in methods of treatment," and "the general lack of information and knowledge on the part of consumers regarding the necessity for medical treatment or the type or extent of treatment needed," AHA Br., at 11-12, somehow sets apart the medical profession. These characteristics are not unique to the medical profession, *see, e.g., Bates v. State Bar of Arizona*, 433 U.S. 350 (1977); *Virginia Pharmacy Board v. Virginia Consumer Council*, 425 U.S. 748 (1976); nor is the medical profession necessarily so esoteric that consumers cannot make effective choices from among competitors thereby driving down the costs of health care.[12] In any event, this Court has already held that considerations of this sort

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[12] *See* Christianson & McClure, *Competition in the Delivery of Medical Care*, 301 New England J. of Medicine 812 (1979); Faltermayer, *Where Doctors Scramble for Patients Dollars*, Fortune Magazine 114 (Nov. 6, 1978); Inglehart, *HMOs Are Alive and Well in the Twin Cities Region*, 10 National Journal 1164 (1978)

cannot excuse a price-fixing scheme. *E.g., National Society of Professional Engineers v. United States, supra,* 435 U.S. 693-96.

Finally, amici argue that the *per se* rule should not be applied because there is no consensus among antitrust law enforcement officials that respondents' conduct is unlawful on its face. CDS Br., at 4, 19-23; AHA Br., at 15-18. The amici point to the Federal Trade Commission as supposedly expressing a dissenting view that a Rule of Reason analysis be applied here. *Ibid.* With all due respect, the amici are in error. The Federal Trade Commission has expressed the view that the *per se* standard is applicable to the present case because of the absence of any economic integration by respondents' member physicians. Federal Trade Commission, *Enforcement Policy with Respect to Physician Agreements to Control Medical Prepayment Plans,* 46 Fed. Reg. 48982, 48989 n.45 (Oct. 15, 1981). The Federal Trade Commission thus joins the Department of Justice which had suggested summary reversal of the Ninth Circuit opinion, the chief law enforcement officers of virtually all 50 states, as well as learned commentators in concluding that the specific practices that respondents engaged in are *per se* unlawful. At least among antitrust law enforcement officials and the commentators,[13] there is the "universal view," *Broadcast Music, Inc. v. Columbia Broadcasting System, Inc., supra,* 441 U.S., at 16, that respondents' activities are *per se* unlawful. This Court should also accept that view.

III. RESPONDENTS' ATTEMPT TO CLOUD THE RECORD MISPERCEIVES THE *PER SE* RULE AND FLIES IN THE FACE OF THEIR OWN CONCESSIONS AND THE LOWER COURT RULINGS

Ignoring the lower courts' rulings that this case "involves a question of law as to which there is substantial ground for difference of opinion," 28 U.S.C.§ 1292(b), and undaunted by their own admission that "the undisputed facts established an agreement

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[13]*See, e.g.,* W. Liebeler, *supra* note 7, at 14; Halper, *The Health Care Industry and the Antitrust Laws: Collision Course?,* 49 Antitrust L.J. 17 (1980); Kallstrom, *Health Care Cost Control by Third Party Payors: Fee Schedules and the Sherman Act,* 1978 Duke L.J. 645.

among physicians . . . that . . . each would accept as payment in full the amount paid by . . . insurance" they endorsed, Br. Opp., at *i*; *accord* Resp. Br., at *i*; respondents nonetheless argue that the facts in the record are disputed and that further discovery is required before this case can be decided. Neither contention has any merit.

Respondents' plea for some unspecified additional discovery overlooks the fact that "[t]here is no reason to protract already complex antitrust litigation by detailed analyses of peripheral economic facts . . . ." *Brown Shoe Co. v. United States*, 370 U.S. 294, 341 (1962). The *per se* rule, after all, is based in part upon the desire to "avoid the necessity for an incredibly complicated and prolonged economic investigation into the entire history of the industry involved." *Northern Pacific R. Co. v. United States*, 356 U.S. 1, 5 (1958). Discovery procedures could, as respondents seem to suggest, be used to compile a treatise on medical economics but such a procedure would be a perversion of the *per se* rule. Nothing said by respondents would justify such a "prolonged economic investigation" before deciding this case.

Respondents repeatedly claim that there is a dispute over the reasonableness of their prices and that their prices are lower than others charged in the marketplace, but any inquiry into the supposed reasonableness of prices is foreclosed by *Socony-Vacuum*: "The reasonableness of prices has no constancy due to the dynamic quality of the business facts underlying price structures. Those who fixed reasonable prices today would perpetuate unreasonable prices tomorrow, since those prices would not be subject to continuous administrative supervision and readjustment in light of changed conditions." 310 U.S., at 221. The wisdom of this statement is amply evidenced by respondents' own history. Respondents apparently began their price-fixing scheme in an effort to exclude HMOs from the marketplace which itself would be unlawful, *see* note 2, *supra*, and then validated the assumption this Court made in *Albrecht* that a maximum price schedule "tends to acquire all the attributes of an arrangement fixing minimum prices." 390 U.S., at 153. During the course of this lawsuit when they had been temporarily enjoined from promulgating new fee schedules, respondents sought permission from the District Court to increase the prices charged by their members by some $1.8 million per month. J.A. 331. Indeed, respondents themselves have argued that their price schedules must

be kept at a sufficiently high level to satisfy their membership, *see* J.A. 322-26, 527-40, and that membership includes most of the physicians practicing in Pima and Maricopa Counties. *See* Pet. Br., at 3. Finally, respondents have used their market power as a price-fixing cartel to foster a variety of other anticompetitive practices. *See id.*, at 6, n.5. There is no need for further inquiry into the reasonableness of respondents' fee schedules.

CONCLUSION

The decision of the Court of Appeals should be reversed and the case remanded with instructions to enter partial summary judgment on the issue of a violation in favor of petitioner.

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No. 80-419

In The

Supreme Court of the United States

October Term, 1980

STATE OF ARIZONA,

Petitioner,

vs.

MARICOPA COUNTY MEDICAL SOCIETY, MARICOPA FOUNDATION FOR MEDICAL CARE, and PIMA FOUNDATION FOR MEDICAL CARE,

Respondents.

ON WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE NINTH CIRCUIT

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QUESTION PRESENTED

Is an agreement among competing physicians establishing fee schedules for their individual services a per se violation of Section 1 of the Sherman Act?

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INTEREST OF AMICI CURIAE

The States of Alabama, Alaska, Arkansas, Colorado, Connecticut, Delaware, Florida, Hawaii, Illinois, Indiana, Iowa, Kansas, Louisiana, Maine, Maryland, Michigan, Minnesota, Mississippi, Missouri, Montana, New Hampshire, New Jersey, New Mexico, New York, North Carolina, North Dakota, Oklahoma, Rhode Island, South Carolina,

South Dakota, Tennessee, Texas, Utah, Vermont, Washington, West Virginia, Wisconsin, Wyoming, and the Commonwealth of Kentucky respectfully submit this brief *amici curiae* in accordance with Supreme Court Rule 36 in support of petitioner the State of Arizona on writ of certiorari to the United States Court of Appeals for the Ninth Circuit.

The respective Attorneys General of these numerous sovereign states are charged with the responsibility of enforcing state antitrust provisions similar or identical to the Sherman Act.[1] These various state antitrust laws are construed in accordance with this Court's interpretation of the federal antitrust laws.[2] Therefore, this Court's determination in this case will directly affect the *amici* states' enforcement of state laws pertaining to restraints of trade and will have an impact far beyond the question of federal law presented herein.

The United States Congress has previously provided for increased state antitrust enforcement through the appropriation of substantial funds to the various state Attorneys General for the purpose of development and expansion of antitrust enforcement capabilities. 42 U. S. C. § 3701 (1976). Congress has also enhanced the enforcement capabilities of the various state Attorneys General through legislation authorizing states to sue as *parens patriae* to recover damages for citizens injured by violations of the Sherman Act. 15 U. S. C. § 15 (c) (1976).

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[1] E. g., Neb. Rev. Stat. § 59-1603 (Cum. Supp. 1978), Ill. Rev. Stat., ch. 38, § 60-30, et seq. (1979); 6 Del. Code Ann. § 2113 (Supp. 1979); Md. Com. Law Code Ann. § 11-202(a)(2) (1975).

[2] E. g., Neb. Rev. Stat. § 59-829 (Cum. Supp. 1978) *State v. Milwaukee Braves, Inc.*, 31 Wis. 2d 699, 716, 144 N. W. 2d 1, 9 (1976).

Given these increased enforcement capabilities and responsibilities, the *amici* states have a direct interest in this Court's interpretation of the standard which should be applied to price fixing activities by professional groups.

The *amici* states are also concerned with the skyrocketing costs of medical care. A decision in the present case establishing a separate standard of antitrust liability for the medical care industry would seriously affect the costs which citizens of the *amici* states are required to pay for proper medical services.

For these various reasons, the *amici* states have direct and substantial interests in the proper resolution of the question presented in this case. Therefore, the *amici* states support petitioner the State of Arizona in this appeal on writ of certiorari to the Ninth Circuit.

QUESTION PRESENTED

Is an agreement among competing physicians establishing fee schedules for their individual services a per se violation of Section 1 of the Sherman Act?

STATUTORY PROVISION INVOLVED

Section 1 of the Sherman Act, 15 U. S. C. § 1 provides, in pertinent part:

> Every contract, combination, in the form of trust or otherwise, or conspiracy, in restraint of trade or commerce among the several States, or with foreign nations, is declared to be illegal.

SUMMARY OF ARGUMENT

The respondents' fee agreements in the present case constitute price fixing. As such, those agreements are clearly illegal per se under the precedent established by this Court. The Ninth Circuit's consideration of the reasonableness of respondents' prices and the Ninth Circuit's apparent recognition of a learned profession exemption in this case ignore the clear directive of Section 1 of the Sherman Act and the well-settled decisions of this Court. The Ninth Circuit should be reversed.

ARGUMENT

I.

The Supreme Court has consistently held that private agreements regarding price are per se unlawful under the Sherman Act. In the present case, the challenged conduct of the respondents constitutes price fixing and is thus per se unlawful.

Over the years, this Court has consistently and repeatedly held that agreements among competitors to fix prices constitute a per se violation of Section 1 of the Sherman Act. *National Society of Professional Engineers v. United States*, 435 U. S. 679 (1978), *United States v. Socony-Vacuum Oil Co.*, 310 U. S. 150 (1940), *United States v. Trenton Potteries Co.*, 273 U. S. 392 (1927). As recently as last year, the Court again restated this basic premise in *Catalano, Inc. v. Target Sales, Inc.*, 446 U. S.

643 (1980). Clearly, any agreement or combination "found for the purpose and with the effect of raising, depressing, fixing, pegging, or stabilizing . . . price . . . is illegal *per se*." *United States v. Socony-Vacuum Oil Co.*, 310 U. S. 150, 223 (1940).

In the present case, the courts below found that respondents and their members set, by majority vote, the maximum amount to be paid member physicians who agree to provide services to patients enrolled in insurance plans approved by the respondents.[3] Furthermore, 85 to 95 percent of the physicians in Maricopa County bill at or above the maximum reimbursement levels set by the respondents,[4] and the respondents have admitted that their member doctors expected concerted price increases as a requisite for continued membership in the foundations.[5] These facts indicate clear and simple price fixing. As Judge Larson noted in his well-reasoned dissent, "it is clear that these activities constituted maximum price-fixing by competitors. Disregarding any 'special industry' facts, this conduct is per se illegal."[6]

As a form of price fixing, respondents' activities are per se unlawful under the cases cited above. However, the Ninth Circuit held that the relevant test of respondents' activities involved consideration of their "impact on com-

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[3]Petitioner's Petition for Writ of Certiorari, Appendix A at 2, Appendix D at 39.

[4]*Id.*, Appendix A at 3.

[5]Petitioner's Petition for Writ of Certiorari, Appendix A at 29-30, Joint Appendix at 326, 334, 336.

[6]Petitioner's Petition for Writ of Certiorari, Appendix A at 20.

petitive conditions."[7] From this language in this Court's decision in *National Society of Professional Engineers v. United States*, 435 U. S. 679 (1978), the Ninth Circuit concluded that a rule of reason analysis was appropriate in the present case. That conclusion is incorrect.

While *Professional Engineers* does indicate that the ultimate test of an agreement's legality is its impact on competitive conditions, the Court's opinion directs that a rule of reason analysis should not be applied when the trade restriction results in the fixing of rates or prices by private agreement.[8] In addition, *Professional Engineers* succinctly describes the two necessary categories of antitrust analysis. The first category includes agreements whose nature and effect are so plainly anticompetitive that no industry study is necessary to establish their illegality. These agreements are illegal per se and their "impact on competitive conditions" is *presumed*. In the second category are agreements whose competitive effect can only be evaluated by a more elaborate study of the industry involved. In this category, a rule of reason analysis is necessary to determine if an anticompetitive impact is present. In the case at bar, the conduct of the respondents constitutes price fixing and is per se illegal. Contrary to the view of the Ninth Circuit, its "impact on competitive conditions" is presumed and no further analysis is necessary.

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[7] *Id.*, Appendix A at 4.

[8] This Court later affirmed the nonapplicability of the rule of reason in *Professional Engineers*, stating that:

> [A]n agreement among competing firms of professional engineers to refuse to discuss prices with potential customers until after negotiations have resulted in the initial selection of an engineer was held unlawful without requiring further inquiry.

Catalano, Inc. v. Target Sales, Inc., 446 U. S. 643, 647 (1980).

The Ninth Circuit also characterized the respondents' activities in the present case as a form of maximum fee agreement and refused to apply a per se rule to those activities based upon its perception that case law is unsettled regarding the proper rule for maximum price agreements in a horizontal setting.[9] The decisions of this Court, however, clearly establish that combinations fixing maximum prices are illegal per se. *Kiefer-Stewart Company v. Joseph E. Seagram & Sons, Inc.*, 340 U. S. 211 (1951), *Albrecht v. Herold Company*, 390 U. S. 145 (1968). Moreover, the language in *Kiefer-Stewart* condemning maximum price fixing was directed towards prices fixed by *horizontal* competitors. Thus, horizontal agreements setting maximum prices are per se illegal. The instant case clearly illustrates the compelling economic underpinning of such a per se rule. As predicted in *Albrecht v. Herold Co., supra*, respondents' supposed maximum prices fixed by agreement have, in reality, become minimum prices in that 85 to 95 percent of the physicians in Maricopa County are charging at or above the respondents' maximum fee schedules.[10]

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[9]Petitioner's Petition for Writ of Certiorari, Appendix A at 7.

[10]Although the courts below characterized the conduct at issue as "maximum" price fixing, respondents' fee schedules also constitute *minimum* price fixing in at least one further very important respect. Health insurance companies are the real consumers of respondents' services. Health insurance companies who want to market foundation-approved plans may not use a fee schedule lower than the one adopted by respondents. For example, member physicians might collectively decide that a given procedure should be compensated up to $1,000. If a health insurance company wished to reimburse that same procedure only up to $800, the foundation would refuse to endorse the plan. Accordingly, from the perspective of the health insurance company and the individuals who ultimately pay the premiums, respondents' fee schedule clearly operates as a form of minimum price fixing.

This Court's decision in *Broadcast Music, Inc. v. Columbia Broadcasting System, Inc.*, 441 U. S. 1 (1979), also does not suggest a rule of reason analysis in the present case. In *Broadcast Music*, the Court considered a system of blanket musical licenses which was *sui generis* and which allowed independent negotiations with individual copyright holders concerning fees for the use of musical compositions. The case at bar does not concern a unique fee arrangement for the delivery of health services, and the respondents' fee agreements do not allow independent negotiations between health insurers and respondents' member physicians. The case at bar further concerns agreements regarding price which were not at issue in *Broadcast Music* where this Court again reaffirmed that, "agreements among competitors to fix prices on their individual goods and services are . . . within the *per se* category." *Id.* at 8.

Respondents in the present case are engaged in simple price fixing. Such conduct should be held to constitute a per se violation of Section 1 of the Sherman Act under the well-settled decisions of this Court.

II.

The Supreme Court has consistently held that the reasonableness of an agreed-upon price is not a defense to a price fixing charge under the Sherman Act. In the present case, the Ninth Circuit erred in considering such a defense relative to the challenged conduct of the respondents.

Over 50 years ago, this Court held that agreements to set prices are per se illegal under the Sherman Act

without consideration of whether the resulting prices are reasonable. *United States v. Trenton Potteries Co., supra.* This principle has been consistently applied in other decisions of this Court,[11] and recently the Court stated, "It has long been settled that an agreement to fix prices is unlawful per se. It is no excuse that the prices fixed are themselves reasonable." *Catalano, Inc. v. Target Sales, Inc., supra* at 647. Clearly, the act of setting prices by private agreement offends the Sherman Act without consideration of whether those prices are themselves reasonable or unreasonable in a given economic setting.

In spite of this established precedent, the Ninth Circuit based its opinion, in part, upon a consideration of the reasonableness of the prices set by the respondents.[12] In his majority opinion, Judge Sneed stated, "[t]he relevant inquiry becomes whether fees paid to doctors under that system would be less than those payable under the FMC maximum fee agreement."[13] Furthermore, Judge Sneed suggested that determination of the legality of the respondents' challenged conduct should include consideration of whether respondents' activities were "devices to enable member doctors to capture a greater share of potential

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[11]*E. g., National Society of Professional Engineers v. United States, supra.*

[12]Respondents claim that the Ninth Circuit did not rely on a reasonableness of price defense. This claim is refuted by the language of Judge Sneed's majority opinion cited above.

[13]Petitioner's Petition for Writ of Certiorari, Appendix A at 6.

monopoly profit,"[14] consideration of how other insurers "fix their fee schedules in the relevant geographical area,"[15] and consideration of the "present supply and demand functions and those which would exist under ideal competitive conditions."[16] These various considerations suggested by Judge Sneed go directly to the reasonableness of the prices set by the respondents. Such considerations are totally irrelevant in the price fixing context of this case. By mandating such reasonableness inquiries, the Ninth Circuit has deviated from the clear rule established by the decisions of this Court. That precedent dictates rejection of any such "reasonableness defense."

III.

The Supreme Court has refused to establish a separate standard of antitrust liability for the "learned professions" in cases involving direct restraints on prices. The Ninth Circuit erred in establishing a separate antitrust liability standard for doctors.

Prior to the Court's decision in *Goldfarb v. Virginia State Bar*, 421 U. S. 773 (1975), some confusion might have existed as to the existence of a so-called "learned profession" exemption from the antitrust laws. However, *Goldfarb* unequivocally establishes that no such sweeping exemption exists. A profession's price fixing activities are now clearly illegal per se under the Sherman Act. Similarly, in *National Society of Professional Engineers v.*

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[14] *Id.*, Appendix A at 6.

[15] *Id.*, Appendix A at 8.

[16] *Id.*, Appendix A at 6.

United States, supra, the Court recognized that "no elaborate industry analysis is required to demonstrate the anticompetitive character of . . . an agreement" when that agreement relates to prices to be charged by a profession. *Id.* at 692. Applying a learned profession exemption to price related activities thus flies in the face of the standard enunciated by this Court.

In his opinion for the Ninth Circuit majority, Judge Sneed chose to focus upon the nature of the health care industry in holding that a per se analysis was inappropriate in the present case. He stated:

> The health care industry, moreover, presents a particularly difficult area. The first step to understanding is to recognize that not only is access to the medical profession very time consuming and expensive both for the applicant and society generally, but also that numerous government subventions of the costs of medical care have created both a demand and supply function for medical services that is artificially high.[17]

Judge Sneed also concluded his opinion by noting this Court's statement in *Professional Engineers* and *Goldfarb* that marketing restraints involving professional competition may be acceptable under a rule of reason analysis where similar restraints involving ordinary business competition are not.[18] Judge Sneed's opinion thus indicates that the Ninth Circuit chose to analyze the industry involved in the case at bar rather than the nature of respondents' conduct, and that the Ninth Circuit recognized a learned profession exemption based upon its perception

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[17] *Id.*, Appendix A at 6.

[18] *Id.*, Appendix A at 12.

of *Professional Engineers* and *Goldfarb*. Those cases, however, stand for the proposition that the correct focus for antitrust analysis is the nature of a challenged practice rather than the characteristics of a particular industry. Those cases further establish that price fixing is illegal per se regardless of the fact that a profession is involved. There is no learned profession exemption from the Sherman Act when, as in the case at bar, the challenged activities directly relate to price. The Ninth Circuit's apparent recognition of a separate standard of antitrust liability for respondent physicians' price agreements contravenes the clear rule established by the decisions of this Court.

The recognition of a learned profession exemption from the antitrust laws in this case is of special concern to the *amici* states. From an enforcement standpoint, if a professional group is free to establish fee schedules unless the states can prove they are unreasonable, it simply will not be practical for the *amici* states to prosecute such cases. Furthermore, if learned professions can fix reasonable price standards for their members, how can the Attorneys General of the various *amici* states advise state officials of the proper standards to follow in regulating professional conduct? Can state bar associations now poll their members and adopt maximum fee schedules? Can real estate brokers now use the state real estate commission to establish uniform fee guidelines? What "professions" regulated by state law qualify for the exemption? The *amici* states respectfully submit that application of a rule of reason standard and recognition of a learned profession exemption in the case at bar will seriously erode

the ability of the states to preserve the competitive forces of the free marketplace.

CONCLUSION

For the foregoing reasons, the *amici* states respectfully submit that the holding of the United States Court of Appeals for the Ninth Circuit should be reversed and that respondents' conduct should be considered per se illegal under the terms of the Sherman Act.

Dated this 3rd day of June, 1981.

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IN THE

Supreme Court of the United States

OCTOBER TERM, 1980

STATE OF ARIZONA, *Petitioner,*

v.

MARICOPA COUNTY MEDICAL SOCIETY, MARICOPA FOUNDATION FOR MEDICAL CARE, and PIMA FOUNDATION FOR MEDICAL CARE, *Respondents.*

On Writ Of Certiorari To The United States Court Of Appeals For The Ninth Circuit

BRIEF FOR AMERICAN ASSOCIATION OF FOUNDATIONS FOR MEDICAL CARE AS *AMICUS CURIAE*

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RESTATEMENT OF QUESTION PRESENTED

Whether a maximum payment schedule developed by a foundation for medical care in connection with a contractual arrangement with an insurance company is *per se* legal under Section 1 of the Sherman Act.

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MARICOPA COUNTY MEDICAL SOCIETY, MARICOPA FOUNDATION FOR MEDICAL CARE, and PIMA FOUNDATION FOR MEDICAL CARE, *Respondents.*

On Writ Of Certiorari To The United States Court Of Appeals For The Ninth Circuit

BRIEF FOR AMERICAN ASSOCIATION OF FOUNDATIONS FOR MEDICAL CARE AS *AMICUS CURIAE*[1]

STATEMENT OF INTEREST

The American Association of Foundations for Medical Care (AAFMC) is the national trade association of foundations for medical care (FMCs or foundations). Presently, thirty-two foundations are active members of AAFMC, including the respondent, Maricopa Founda-

[1] Petitioner and respondents have consented to the appearance of American Association of Foundations for Medical Care as *Amicus Curiae* in this case. Copies of the letters of consent have been filed with the Clerk of the Court.

tion for Medical Care. Five other foundations are associate members.

As the national association, AAFMC is interested in promoting foundation-sponsored health plans offered by health insurance companies. These plans effectively control health care costs through a variety of related activities. Maximum payment schedules, which are adopted by insurers under their arrangements with FMCs, form an integral part of these plans. Indeed, maximum payment schedules are an essential element in foundations' efforts to contain the costs of health care.

AAFMC's interest in this case is to promote flexibility in the manner in which its member foundations will be permitted to operate. In this connection, AAFMC has a complete understanding of FMCs' current operations.

This case goes to the heart of the operations of AAFMC's member foundations. If this Court holds that maximum payment schedules are *per se* illegal the impact on AAFMC's members will be devastating, and an effective cost containment mechanism will be lost.

AAFMC submits that the rule of reason is the correct method for analyzing maximum payment schedules developed by FMC's in conjunction with insurers or self-insurance plans. Application of the rule of reason will provide the courts with the flexibility to strike down anticompetitive practices when they occur, yet permit the maximum payment schedules operating in the public interest.

SUMMARY OF ARGUMENT

Per se analysis may only be applied to "naked restraints" falling within section 1 of the Sherman Act[2] which have no possible justification. In order to determine whether the *per se* rule should apply, the Court must undertake a threshold examination into the nature of the restraint, its purpose and effect, as well as the nature of the industry. Examination of these factors in connection with maximum payment schedules reveals that such schedules are not properly characterized as "price fixing" by competitors.

The actions of an FMC in conjunction with an insurer cannot be attributed to the participating physicians of the FMC without additional evidence. This must be determined on a case-by-case basis. Morever, a maximum payment schedule does not fix prices. Under this schedule, physicians are free to set any price they choose for their services. They are merely constrained from receiving payment in excess of the maximum from an insurer contracting with the FMC. Indeed, the FMC has no power to fix prices. Only the insurer has the power to enforce the maximum payment. Finally, the maximum payment schedule is permissible under the antitrust laws because it is necessary in order to enable an insurer to offer an FMC-sponsored health benefits plan.

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[2] 15 U.S.C. §1 (1976)

FACTUAL BACKBGROUND

I. COMPETITION IN THE PHYSICIAN SERVICES MARKET

A. The Market For Physician Services Is Unique And Not Well Understood.

If we have learned anything from the comments of economists and other scholars who have studied competition in the physician's services market, it is that competition in that market is qualitatively different from competition in many other markets, and that the variety of factors impacting upon the market are not well understood.[3] Economists are only now beginning to study the interrelationships among the factors that make competition in the physician services market unique. Although it is becoming clear that certain factors present in other competitive markets impact on the market for physician services, it is also clear that presence of certain factors, such as third party insurance, complicate the analysis.[4] In order for this Court to render an informed decision in this case, it must take notice of certain basic factors in the market within which any allegedly anti-competitive restraints operate.[5]

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[3] *See generally,* Competition in the Health Care Sector: Past, Present and Future (W. Greenberg ed. 1978) (proceedings of a conference sponsored by the FTC Bureau of Economics).

[4] *See, e.g.,* J. Newhouse, *The Structure of Health Insurance and the Erosion of Competition in the Medical Marketplace,* in *id.* at 270.

[5] The brief synopsis outlined herein presents the market as it exists. It has been argued that, as there is no competition in the physician services market, by definition, there can be no reduction.

The State of Ohio, in its Brief *Amicus Curiae*, points out certain factors which create "perverse incentives" for physicians to raise

Competition in the physician services market is atypical. Ordinarily, a consumer in the marketplace is presented with a choice of products of varying quality and at varying prices. The economic choice such a consumer must make involves a trade-off between quality and cost. In the market for physician services, however, the choice facing the consumer may be somewhat different. Although an uninsured patient who pays for services out of pocket on a fee-for-service basis faces economic choices similar to those in any normal business market, the insured consumer[6] is directly concerned only with the quality of services and is only indirectly concerned with their price.[7]

It is clear that the patient's range of choice of physicians may be restricted by the market. In many cases, particularly those which involve acute care, a patient does not exercise choice among physicians. In such a case, a patient must often accept the physician on call at the hospital. Further, once care is initiated by a physician, the patient often has no choice regarding which services are performed, which supplies are purchased, or

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prices. Brief for the State of Ohio as *Amicus Curiae*, at 3-6. Yet, it is clear that the interest of the State of Ohio is to revamp completely the nature of competition in the market. *Id.* at 7-9. That purpose is essentially irrelevant to the issue at hand which is whether the maximum payment schedule is an illegal restraint of trade.

[6] As this case involves FMCs which deal only with insured patients, they are the relevant consumers for purposes of analysis.

[7] Consumers whose health insurance is entirely paid for by their employers have no concern for physicians' prices to the extent that the insurer pays the entire amount of the physician's fee. They may, however, be indirectly concerned with physicians' fees to the extent that they relate to the cost of health insurance which is the subject of a collective bargaining agreement.

which specialists are consulted. Moreover, some insurers place maximum limitations on payment for services. This limitation, however, means only that the differential is paid directly by the patient.

Insurance companies often do consider price. However, here, as well, market forces operate differently from those of the normal business market. As the insurer does not itself receive the services, it is necessarily less directly concerned with quality than the ordinary consumer. Moreover, many insurers have, in effect, taken themselves out of the market with regard to quality by accepting the principle of freedom of choice.[8]

In contrast to the market for physician services, the market for health insurance involves both quality and price. Yet, here as well, the incentives are vastly different from those in a typical market. To the extent that health insurance is an employee benefit, price may be removed as a consideration of an employee in choosing a benefits plan.[9] Even if an employee shares the cost of health insurance, price competition among insurers for enrollees is minimized, because the actual cost of any package is greater than the price directly faced by the employee. Moreover, competition over quality in this market relates to comprehensiveness of the services covered and reliability of the plan as well as to quality of services offered by a plan's physicians. Indeed, in plans permitting freedom of choice, quality of services is not a major factor because the consumer may choose any primary care physician.

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[8] The notable exception of health maintenance organizations (HMOs) is discussed *infra* at pages 8, 19.

[9] Price may be a factor to the extent a patient may be billed by a physician for the excess over covered charges.

B. The Role Of Foundations For Medical Care.

Since their inception in the 1950's, FMCs have played an important role in controlling the cost and improving the quality of medical care provided to consumers through third party insurers.[10] The stimulus responsible for the initial development of FMCs was dissatisfaction with existing forms of health insurance. Typically, benefits packages operated on an indemnity basis and generally were not comprehensive. Payment for many services was dependent upon hospitalization, thereby encouraging unnecessary hospitalization and increasing the cost of health care. Faced with the difficult choice of providing services on an uncovered basis or unnecessarily hospitalizing a patient to ensure coverage, some physicians responded by urging the creation of more appropriate benefits packages which would protect the patient by holding down costs and insuring appropriateness of care.

These physicians organized FMCs to contract with insurers to provide care to patients.[11] Early in their history, FMCs recognized that the prevailing use of the "usual and customary" fees dramatically increased costs to insurers, and, more importantly, to patients. Thus, the maximum payment schedule was born as an additional significant means of controlling costs. These schedules, which are typically set substantially below usual and customary fees, were combined with agreements which required the participating physician to ac-

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[10] *See generally* R. Egdahl, *Foundations for Medical Care,* 288 New Eng. J. Med. 491 (1973).

[11] There is a second type of FMC which provides only peer review services. However, the concern here is solely with those that provide care on a contractual basis with insurers.

cept payment from the contracting insurer as payment in full for services rendered. As a result, the patient was protected against any requirement for payment of fees above the schedule.

Subsequently, as data regarding care and utilization grew, FMCs also initiated peer review programs to review the quality and appropriateness of care provided. These programs had the added benefit of reducing costs, for they foreclosed payment for unnecessary services. Additionally, some FMCs began to process claims for their contracting insurance companies.

A more recent development in the history of the health care industry has been the appearance of health maintenance organizations. HMOs, many of which have their roots in FMCs,[12] developed when some physicians decided to limit the participation of third party insurers. In an HMO setting, the physicians themselves underwrite a large portion of the risk, contracting out only exceptional risks.

ARGUMENT

I. DETERMINATION OF THE PROPER METHOD OF ANALYSIS REQUIRES REVIEW OF THE NATURE OF THE ACTIVITY WITHIN THE CONTEXT OF THE HEALTH INDUSTRY AS WELL AS POTENTIAL JUSTIFICATIONS FOR THAT ACTIVITY

In order to determine whether a maximum payment schedule should be classified as a *per se* violation, or whether it requires analysis under the rule of reason, the Court must undertake an inquiry into the nature of the

[12] Indeed, the San Joaquin Foundation, a prototype foundation, was also identified as a model for the federal Health Maintenance Organization Act of 1973 as amended, 42 U.S.C. 300e *et seq.* (1976 & Supp. III 1979).

alleged restraint and its potential justifications. As Mr. Justice Brandeis stated in *Board of Trade* v. *United States*:

> The true test of legality is whether the restraint imposed is such as merely regulates and perhaps thereby promotes competition or whether it is such as may suppress or even destroy competition. To determine that question the Court must ordinarily consider the facts peculiar to the business to which the restraint is applied; its condition before and after the restraint was imposed; the nature of the restraint and its effect, actual or probable. The history of the restraint, the evil believed to exist, the reason for adopting the particular remedy, the purpose or end sought to be obtained, are all relevant facts. This is not because a good intention will save an otherwise objectionable regulation but because knowledge of intent may help the court to interpret facts and to predict consequences.

246 U.S. 231, 238 (1918).

At first, all restraints of trade were analyzed under the "rule of reason" structure outlined by Mr. Justice Brandeis and others. However, as the Court discovered that certain kinds of agreements were so manifestly anticompetitive that there was no possible justification for their existence, *per se* categories began to develop. *See, e.g., Northern Pacific Railroad* v. *United States*, 356 U.S. 1 (1958) (tying arrangement); *United States* v. *Trenton Potteries Co.*, 273 U.S. 392 (1927) (price fixing) (*Trenton Potteries*); *United States* v. *Addyston Pipe & Steel Co.*, 85 F. 271 (6th Cir. 1898), *aff'd as modified*, 175 U.S. 211 (1899) (market allocation) (*Addyston Pipe & Steel*). The *per se* rules thus reflect the judgment that, within these categories of naked restraints, cases which do not fit the general rule "are not sufficiently common or important to justify the time and expense necessary to

identify them." *Continental T.V., Inc.* v. *GTE Sylvania, Inc.* 433 U.S. 36, 50 n.16 (1977) (*Continental T.V.*).

When a court encounters a particular restraint, it should make a threshold two-fold inquiry to determine whether *per se* or rule of reason analysis should be applied. First, it should identify the nature of the restraint and the industry in which it operates to determine whether it is identical to other restraints which have been characterized as *per se* offenses. If the court concludes that it is not, it should next review the justifications offered in defense of the challenged restraint.

In particular, the Court should review the purpose and history of the restraint, its effect on the industry, and whether the restraint is pro-competitive in any way. *See Broadcast Music, Inc.* v. *Columbia Broadcasting System, Inc.*, 441 U.S. 1, 99 S. Ct. 1551 (1979) (*Broadcast Music*). If, upon this review, the court determines that the restraint has no possible justification it should be condemned as *per se* illegal without further analysis. *See National Society of Professional Engineers* v. *United States*, 435 U.S. 679, 680 (1978) (*Engineers*)[13]; On the other hand, if the Court finds the existence of potential justifications, the restraint should be analyzed under the rule of reason. *See Broadcast Music*, 99 S. Ct. at 1565. In *Broadcast Music*, for example, this Court found that rule of reason analysis was appropriate (even though the arrangement literally "fixed" a price) because of the existence of several justifications.

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[13] In *Engineers*, the Court found that there was no possible justification for the total ban on competitive bidding effected by the society's rules.

Many lower courts have held that the *per se* rules are not applicable at all when the peculiar characteristics of an industry necessitate certain anti-competitive behavior. *E.g., Mackey* v. *National Football League*, 543 F.2d 606, 619 (8th Cir. 1976), *cert. dismissed*, 434 U.S. 801 (1977). AAFMC submits that market conditions in the health care industry are sufficiently peculiar, and that exceptions to any general rule are sufficiently common and important to outweigh any administrative advantages of the *per se* rule. Rule of reason analysis is also appropriate here, in view of the Court's lack of experience with the health care industry and with maximum payment schedules as applied in a professional rather than commercial setting.[14] *See Broadcast Music*, 99 S. Ct. at 1557; *Engineers*, 435 U.S. at 687-92; *Goldfarb* v. *Virginia State Bar*, 421 U.S. 733, 788-89 n.17 (1975) (*Goldfarb*). Indeed, courts have consistently found the rule of reason to be the appropriate method of dealing with the variety of situations which have arisen in the health care industry. *See e.g., Virginia Academy of Clinical Psychologists* v. *Blue Shield*, 624 F.2d 476, 485 (4th Cir. 1980) (*Virginia Academy*); *Sausalito Pharmacy, Inc.* v. *Blue Shield*, [1980-81] Trade Cas. (CCH) ¶ 63,695 at 77,724-25 (N.D. Cal. May 12, 1980); *United States* v. *American Society of Anesthesiologists*, 473 F. Supp. 147, 157 (S.D.N.Y. 1979).

[14] The State of Ohio apparently attempts to establish the requisite experience by reference to *United States* v. *American Medical Association*, 317 U.S. 519 (1943). Yet that case dealt only with a boycott and with the applicability of the labor exemption. The court was not required to consider the factors relating to competition in the market for physician services. Moreover, similar circumstances existed in *Broadcast Music*. The Justice Department had first investigated allegations of anticompetitive conduct fifty years prior to that decision, and a consent decree had been entered into 38 years before the decision.

II. ESTABLISHMENT OF A MAXIMUM PAYMENT SCHEDULE BY AN INSURER IN CONNECTION WITH AN FMC IS NOT A TRADITIONAL NAKED RESTRAINT

It can hardly be questioned that maximum payment schedules can be a legitimate and important element in a health insurance plan. What is at issue is whether a foundation can play a legitimate role in the establishment of such schedules. We submit that they can. FMCs are independent corporations with interests that are not necessarily coextensive with the individual interests of the physician membership. FMCs can provide insurers with useful information regarding existing physician fee and participation patterns which are important in establishing maximum payment rates.[15] Insurers are, of course, free to reject any maximum payment schedule developed and, indeed, to refrain from doing business with FMCs as they typically have no monopoly power.

A. The Maximum Payment Schedule Is Not Set By Competitors.

Without evidence to the contrary, the development of a maximum payment schedule by an FMC is not joint action by competitors, but merely the act of a corporate entity. It cannot constitute an antitrust violation, for a corporation cannot conspire with itself. *Nelson Radio & Supply Co.* v. *Motorola, Inc.*, 200 F.2d 911 (5th Cir. 1952), *cert. denied*, 345 U.S. 925 (1953). Moreover, an arrangement between an FMC and an insurer involving a maximum payment schedule is permissible as nothing more than an arms-length business arrangement.

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[15] While some insurers have the data base to perform these functions internally, others do not.

It is true, of course, that in some circumstances, the action of an FMC may be attributed to the joint action of its member physicians. *See Virginia Academy*, 624 F.2d at 479-81 (4th Cir. 1980). However, this must be determined as a factual matter on a case-by-case basis under the rule of reason. *See id.* at 481.

In this connection, it must be noted that the method of establishing the maximum payment schedule varies among FMCs. Some foundations grant member physicians voting rights regarding the establishment of the fee schedule. Other FMCs provide indirect methods of participation, such as polling. In other cases, rates are set by the Board of Directors, or a committee of the foundation without any participation by the membership. Typically, the maximum payment levels are not circulated to the membership. The impact of each of these types of participation and other factors must be weighed individually.

B. A Maximum Payment Schedule For Physician Services Is Not Price Fixing.

In those circumstances in which the Court has considered maximum pricing, it has been treated as if it were minimum pricing. *See Albrecht* v. *Herald Co.*, 390 U.S. 145 (1968) (*Albrecht*); *Kiefer-Stewart Co.* v. *Joseph E. Seagram & Sons, Inc.*, 340 U.S. 211 (1951) (*Kiefer-Stewart*).[16] The rationale expressed for such identical

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[16] There is some question whether the *Albrecht* rule is correct. As Mr. Justice Harlan stated:

> Both practices [price ceilings and price floors] share the negative attribute that they restrict individual discretion in the pricing area, but only the former imposes upon the public the much more significant evil of lessened competition, and, as just seen, the latter has an important arguable justification [pre-

treatment was that agreements to fix maximum prices "no less than those to fix minimum prices . . . restrain their [the sellers'] ability to sell in accordance with their own judgment." *Kiefer-Stewart*, 340 U.S. at 213; *see also Albrecht*, 390 U.S. at 152. Additionally, identical treatment was justified because "if the actual price charged under a maximum price scheme is nearly always the maximum price . . . the scheme tends to acquire all the attributes of an arrangement fixing minimum prices." *Albrecht*, 390 U.S. at 154.

In order to constitute price fixing under *Kiefer-Stewart* and *Albrecht*, a maximum payment schedule must significantly interfere with the physician's ability to set his or her own rates. Yet, a physician who chooses to participate in an FMC-sponsored health plan agrees only that he will accept the maximum allowable fee as full payment for any particular service provided to a patient insured by the plan. The physician remains free to establish higher or lower rates for services in accordance with his "usual and customary" fees. Indeed, the physician may collect higher fees from other insurers or direct-pay patients. The only constraint upon the physician is that he may not collect more than the maximum amount from the FMC-sponsored insurer.

The rationale expressed in *Kiefer-Stewart* and *Albrecht* does not, therefore, apply to an FMC maximum payment schedule. Both *Kiefer-Stewart* and

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venting monopoly or supercompetitive profits] that the former does not possess. In a maximum price case the asserted justification must be met on its merits, and not by incantation of a *per se* rule developed for an altogether different situation.

390 U.S. at 159 (Harlan, J. dissenting); *see also* 390 U.S. at 168-70 (Stewart, J. dissenting). Several commentators have also taken issue with the rule established in *Albrecht*. *See* 10 B.C. Indus. & Com. L. Rev. 208, 215 (1969); 37 U. Cin. L. Rev. 411, 415-16 (1968).

Albrecht involved restraints imposed by a manufacturer on a distributor in a market that was amenable to price competion. In such a situation the manufacturer establishes both the cost of the product supplied and the maximum price for which the product may be sold by the distributor. Thus, the manufacturer would control the profit margin of the distributor. As the profit margin approaches zero, i.e., as the cost of the product approaches the maximum selling price, the maximum price would tend to become the actual price. As the court pointed out in *Albrecht,* under this circumstance the maximum price fixing mechanism acquires the attributes of an arrangement fixing minimum prices. 390 U.S. at 153.

Here, the considerations are different. The entities imposing maximum allowable payments do not control the profit margin because they do not control physician costs. There is, therefore, considerably more latitude for price differentials in this case than in *Albrecht* or *Kiefer-Stewart* because physicians' costs may be different. Moreover, maximum payment schedules are typically set substantially below the average usual and customary fees for physicians in the community. Indeed, by agreeing to participate in a foundation-sponsored health plan, the participating physician trades a reduction in charge for assurance of prompt payment in full. Finally, participating physicians do not always charge the maximum allowable price for services.[17] All of these factors, taken together, indicate that the establishment of a maximum payment schedule is far different from the establishment of a minimum price by competitors.

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[17] Evidence that all FMC physicians charge the maximum price would constitute evidence of a minimum price fixing scheme. This factual matter should be determined on a case-by-case-basis.

C. FMCs Do Not Have Sufficient Coercive Power To Enforce Prices.

The power to set prices requires the power to enforce them. *See United States* v. *Socony-Vacuum Oil Co.*, 310 U.S. at 210 ("where the members of a combination had the power to raise prices . . ."); *Trenton Potteries*, 273 U.S. at 394 (control of substantial part of the industry).

Prices may be imposed vertically, as in *Continental T.V.*, where the resale price was imposed by the newspaper upon distributors, or they may be imposed horizontally as in *Trenton Potteries*, where competitors agreed to maintain a price. Professional associations have also imposed and enforced restraints upon price competition. *See Engineers*, 435 U.S. at 684 n.5 (ethical restrictions on competitive bidding); *Goldfarb*, 421 U.S. at 781-83 (adherence to minimum fee schedule subject to enforcement by disciplinary measures). Such restraints have both horizontal and vertical elements.

Unlike the professional society in *Engineers* or the bar association in *Goldfarb*, an FMC does not have the power to enforce adherence to the maximum payments schedule. An FMC is not a professional association. It does not possess the ethical authority or coercive ability of a bar association or a medical society. At most, an FMC has only the power to exclude a physician from participation in the plan, and it is unclear that such a threat is sufficiently coercive given the nature of the market.[18]

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[18] Many FMCs have strict limitations governing exclusion and expulsion of member physicians. Fee levels are ordinarily not among the acceptable reasons.

Perhaps the most important reason that FMCs do not have the power to enforce maximum payment schedules is the availability of options out of the system. *Compare Broadcast Music with Goldfarb.* Unlike the situation in *Goldfarb,* where state law required title searches to be conducted by attorneys, patients and insurers have options other than dealing with the FMC. Patients may purchase other indemnity plans, join an HMO or pay physicians directly. In fact, FMC plans typically represent only a small portion of the insured market. Moreover, a patient's choice of physician will not be affected, as FMCs do not have exclusive arrangements with participating physicians. In the absence of such an exclusive arrangement, insurers are also free to negotiate with individual physicians or with groups of physicians.

The availability of the options out of the system effectively precludes FMC from exercising sufficient market control to enforce the maximum payment schedule.[19] As in *Broadcast Music,* the consumers in the market for physician services "have a real choice." 99 S. Ct. at 1564. Because there is "no legal, practical or conspirational impediment to obtaining individual [contracts]," there is no price fixing scheme. *Id.; see also K-91, Inc.* v. *Gershwin Publishing Corp.,* 372 F.2d 1, 4 (9th Cir. 1967), *cert. denied,* 389 U.S. 1045 (1968).

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[19] Of course, if an FMC organized or participated in a boycott of an insurer by member physicians as a result of negotiations over fees, the FMC and its member physicians could be held liable for a concerted refusal to deal. *See In re Michigan Medical Society,* FTC Docket No. 9129 (June 22, 1981) (using rule of reason analysis). A similar result might obtain if the FMC established formal exclusive arrangements with a substantial number of participating physicians. There is no evidence in the record that the respondent foundations engaged in any such activity.

D. A Maximum Payment Schedule Is Necessary To The Offering Of A Health Benefits Package.

Courts have historically recognized that certain arrangements which may affect prices should not be analyzed under the price fixing rules. *See Addyston Pipe & Steel,* 85 F. at 281-82. This philosophy was recently affirmed by this Court in *Broadcast Music.* Per Mr. Justice White, writing for the majority:

> Mergers among competitors eliminate competition, including price competition, but they are not *per se* illegal and many of them withstand attack under any existing antitrust standard. Joint ventures and other cooperative arrangements are also not usually unlawful, at least not as price fixing schemes, *where the agreement in price is necessary to market the product at all.*

99 S. Ct. at 1564 (emphasis supplied).

An FMC-sponsored health plan is, in effect, a joint venture between the insurer and the FMC. The insurer obtains benefits from the joint venture in the form of the ability to advertise as an FMC-sponsored plan, and to receive the benefit of the services provided by the FMC. The FMC and its member physicians benefit by having a prompt and reliable source of payment for bills.

An FMC maximum payment schedule is a legitimate component of an FMC-sponsored health plan offered by an insurer. It enables the insurer to more accurately predict its maximum costs and set its premium rates accordingly,[20] as well as to contain costs.

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[20] In the absence of the maximum fee schedule, some other predictive mechanism would necessarily evolve. One option would be a return to the more inflationary usual, customary and reasonable rates.

This characterization is clearest when physicians accept a greater portion of the risk. The resulting HMO is most aptly characterized as a joint venture among the participating physicians. In this setting, the ability to predict costs accurately is essential to the ability to offer a benefit package and a maximum payment schedule should certainly be permitted. *See Addyston Pipe & Steel,* 85 F. at 281-82; Brief for the United States as *Amicus Curiae* on Petition for Writ of Certiorari at 10 n.9; Brief For The State of Ohio as *Amicus Curiae* at 22-23. However, many other types of FMC-insurer arrangements can be characterized as legitimate joint ventures as well. Courts should be free to examine the many different varieties on a case-by-case basis.

CONCLUSION

For the foregoing reasons, AAFMC, as *amicus curiae,* respectfully requests this Court to affirm the decision of the United States Court of Appeals for the Ninth Circuit.

Respectfully submitted,

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No. 80-419

IN THE

Supreme Court of the United States

OCTOBER TERM, 1980

STATE OF ARIZONA, *Petitioner,*

v.

MARICOPA COUNTY MEDICAL SOCIETY, MARICOPA FOUNDATION FOR MEDICAL CARE, and PIMA FOUNDATION FOR MEDICAL CARE, *Respondents.*

On Writ of Certiorari To The United States Court Of Appeals For The Ninth Circuit

BRIEF FOR THE AMERICAN HOSPITAL ASSOCIATION AS *AMICUS CURIAE*

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On Writ of Certiorari To The United States Court Of Appeals For The Ninth Circuit

BRIEF FOR THE AMERICAN HOSPITAL ASSOCIATION AS *AMICUS CURIAE*

INTEREST OF THE AMERICAN HOSPITAL ASSOCIATION

The American Hospital Association ("AHA") represents more than 6,300 health care institutions, including most of the nation's hospitals, long-term care institutions, mental health facilities and hospital schools of nursing. As such, AHA is intimately concerned with the ability of the nation's health delivery system to respond to demands for care in a cost-effective, competent and dependable manner.

Considerations of price, quality and availability of service are as much a part of the health delivery system as of any other marketplace. However, the nature, size and variants of the market participants in the health field distinguish it from other commercial marketplaces.

The juxtaposition of the system's participants, the frequently distorted incentives spawned by the third-party payment mechanism and by the nature and extent of demand, the needs of and for physicians to respond to that demand, and the impact of modern technology contribute to make the health delivery system one of several atypical and unusual markets.

In light of the mission of AHA members to serve the health care needs of the nation, and the importance of their succeeding in an unusual market, the American Hospital Association has a particular interest in the legal issues which surround that marketplace.

This interest is manifest in the desire of AHA to lend its support, not to seek special consideration for its field nor exemption from either the law or forces that govern everyone, but rather to reinforce the contention that issues relating to the health care marketplace should be examined on case-by-case basis — a Rule of Reason — rather than be governed by assumptions borrowed from other fields or growing out of experience and facts which are either nonexistent or yet unproven in the field of health delivery.

SUMMARY OF ARGUMENT

The health care delivery system is one of the unusual market situations for which it is necessary to make a careful examination of the attendant business relationships in order to assess the competitive impact of any particular conduct. The market in the health services industry differs significantly from the more common commercial marketplaces in which consumers are expected to make their purchases in response to differences in the price and quality of the available goods and services. Consumers of health care are patients who do not

generally make the same kinds of choices. The system of third-party reimbursement for health care and of favorable tax treatment for medical expenses dissipates the kind of incentive that is present in a typical commercial context where consumers shop for the highest quality at the lowest price. An additional problem for consumers of health services is their lack of adequate knowledge to fairly evaluate the need for treatment or the medical procedures to be used.

Because the competitive impact of conduct is dependent upon the nature of the industry within which the conduct occurs, the competitive effects of any particular conduct in the health care delivery system may differ significantly from the effects of similar conduct in a different type of marketplace. It is therefore important to note that while the establishment of maximum prices has been ruled upon when examined in the context of true commercial industries, the courts have not had enough experience with the type of conduct practiced by Respondents in establishing maximum reimbursement levels to know what effect this practice has on competition within the health care field.

Price competition is relatively new to the health care delivery system. How that unique system will react competitively to any specific conduct is as yet not conclusively determined. Application of the Rule of Reason standard of liability is therefore necessary to evaluate the conduct in question and to determine the competitive effect it has on the market in the health services industry.

ARGUMENT

I. Introduction

Respondent Foundations for Medical Care ("FMCs") established maximum levels of reimbursement that their physician members could claim as payment-in-

full for health services provided to policyholders of FMC-approved insurance plans. Petitioner requested, and was denied, summary judgment on the issue of Respondents' antitrust liability for this conduct.[1] The denial was proper because the conditions for summary judgment required by the Federal Rules of Civil Procedure ("Federal Rules")[2] have not been satisfied. The Federal Rules require that summary judgment be granted only in cases where (1) ". . . there is no genuine issue as to any material fact and [2] . . . the moving party is entitled to a judgment as a matter of law."[3] In the case at bar, these two criteria could be met only by concluding that Respondents' conduct was *per se* violative of the antitrust laws and that therefore no other facts relating to the disputed activity need be examined. Through this amicus brief, the American Hospital Association intends to reinforce the Respondents' contention that the lower courts were correct in denying summary judgment. Application to the facts of this case of a *per se* standard of illegality in the context of the health care delivery system is inappropriate and inconsistent with this Court's prior decisions.

II. The Competitive Impact Of Conduct Is Necessarily Affected By The Nature Of The Industry In Which The Conduct Occurs

Section 1 of the Sherman Act prohibits "every contract, combination . . . or conspiracy, in restraint of trade or commerce among the several states."[4] Because a

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[1] *Arizona* v. *Maricopa County Medical Soc'y*, 643 F.2d 533 (9th Cir. 1980), *cert. granted* 101 S. Ct. 1512 (1981).

[2] *See Fed. R. Civ. P.* 56(c).

[3] *Id.*

[4] 15 U.S.C. §1 (1976).

literal interpretation of this language would prohibit virtually any contract or agreement in the marketplace, this Court has held that only those agreements which "unreasonably" restrain trade are prohibited by the Act.[5] However, certain types of agreements have been identified as being so consistently unreasonable that they may be deemed to be illegal *per se*, without inquiry into their purported justification.[6]

> [T]here are certain agreements or practices which because of their pernicious effect on competition and lack of any redeeming virtue are conclusively presumed to be unreasonable and therefore illegal without elaborate inquiry as to the precise harm they have caused or the business excuse for their use.[7]

In order to assess whether conduct meets that criteria for application of the *per se* rule, *i.e.* a "pernicious effect on competition and lack of any redeeming virtue," this Court has held that the standard may be applied only after considerable experience with disputed business relationships.[8] This requirement cannot be satisfied by transposing the experience of relationships in one type of industry marketplace to another industry marketplace which is neither similar nor comparable in nature. Thus, the special characteristics of the particular marketplace must be examined in the process of evaluating the impact of any challenged conduct.

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[5] *See Northern Pac. Ry.* v. *United States*, 356 U.S. 1 (1958); *Chicago Board of Trade* v. *United States*, 246 U.S. 231 (1918); *Standard Oil Co.* v. *United States*, 221 U.S. 1 (1911).

[6] *See Northern Pac. Ry.* v. *United States*, 356 U.S. at 5 (1958); *Mackey* v. *National Football League*, 543 F.2d 606, 618 (8th Cir. 1976), *cert. dismissed* 434 U.S. 801 (1977).

[7] *Northern Pac. Ry.* v. *United States*, 356 U.S. at 5.

[8] *See Broadcast Music, Inc.* v. *Columbia Broadcasting System, Inc.*, 441 U.S. 1, 9 (1979); *United States* v. *Topco Associates, Inc.*, 405 U.S. 596, 607-608 (1972).

Contrary to petitioner's assertion,[9] it is proper and necessary to focus on the nature of the industry involved in disputed activity before deciding whether to apply the *per se* standard of illegality or to judge facts under the Rule of Reason. This Court thoroughly examined the nature of the industry involved in the case of *Broadcast Music, Inc.* v. *Columbia Broadcasting System, Inc.*[10] before deciding that, under the circumstances inherent in the market for performing rights for copyrighted musical compositions, the blanket licenses at issue did not constitute price fixing *per se* unlawful under the antitrust laws.[11]

Similarly, in *Mackey* v. *National Football League* ("NFL"),[12] the Eighth Circuit rejected the District Court's finding that the NFL's Rozelle Rule ("Rule")[13] was a *per se* violation of the Sherman Act. The Court stated that the unusual circumstances of the case made it inappropriate to declare the Rule illegal *per se* without undertaking an inquiry into the purported justifications for it.[14] Although enforcement of the Rule allegedly constituted a group boycott and a concerted refusal to deal, it was necessary to test its validity under the Rule of Reason because "the unique nature of the business of professional football render[ed] it inappropriate to mechanically apply per se illegality rules. . . ."[15] Citing

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[9] *See* Brief for Petitioner at 16, filed June 5, 1981.

[10] 441 U.S. 1 (1979).

[11] *Id.*

[12] 543 F.2d 606 (8th Cir. 1976), *cert. dismissed* 434 U.S. 801 (1977).

[13] The Rozelle Rule is the NFL's rule which allows the league commissioner to require the club acquiring a free agent to compensate the free agent's former club.

[14] *Mackey* v. *National Football League*, 543 F.2d at 619.

[15] *Id.*

White Motor Co. v. *United States*,[16] in which this Court rejected the application of *per se* rules to vertically imposed territorial restrictions, the Eighth Circuit stated that "when faced with a unique or novel business situation, courts have eschewed a *per se* analysis in favor of an inquiry into the reasonableness of the restraint under the circumstances."[17]

In *Goldfarb* v. *Virginia State Bar*,[18] which involved minimum fee schedules established by a bar association, this Court unanimously concluded that the antitrust laws are applicable to professions.[19] However, there was language in *Goldfarb's* now famous footnote seventeen which has been interpreted to allow special treatment for professionals.[20] This language was later qualified in *National Society of Professional Engineers* v. *United States*,[21] a case in which this Court examined a section of the canon of ethics of the National Society of Professional Engineers that prohibited members from submitting competitive bids for engineering services. In *Professional Engineers*, this Court stated that footnote seven-

[16] 372 U.S. 253 (1963).

[17] *Mackey* v. *National Football League*, 543 F.2d at 619.

[18] 421 U.S. 773 (1975).

[19] *Id.* at 787.

[20] "The fact that a restraint operates upon a profession as distinguished from a business is, of course, relevant in determining whether that particular restraint violates the Sherman Act. It would be unrealistic to view the practice of professions as interchangeable with other business activities, and automatically to apply to the professions antitrust concepts which originated in other areas. The public service aspect, and other features of the professions, may require that a particular practice, which could properly be viewed as a violation of the Sherman Act in another context, be treated differently. We intimate no view on any other situation than the one with which we are confronted."

421 U.S. at 788 n.17.

[21] 435 U.S. 679 (1978).

teen in *Goldfarb* does not provide a broad exemption under the Rule of Reason for learned professions. However, the Court did not provide explicit guidance as to how restraints by professionals should be analyzed. The Court stated that the purpose of judicial analysis in antitrust cases is to form a judgment about the competitive significance of the restraint[22] and that the Rule of Reason analysis only permits procompetitive justifications. The Court did however adhere to the view expressed in *Goldfarb* that "by their nature, professional services may differ significantly from other business services, and accordingly, the nature of the competition in such services may vary."[23] It is significant that whatever else was at issue, this Court reinforced the fundamental notion that the competitive effects of conduct will differ depending on the context in which the activity occurs, or the nature of the industry in question. Without granting special treatment for professions, the *Professional Engineers* opinion expressly noted that the competitive impact of conduct may vary in different industries. This notion was reaffirmed in *Broadcast Music, Inc.*

III. The Unique Nature Of The Health Care Delivery System Distinguishes It From General Commercial Industries

The most significant question before this Court is whether *per se* rules of illegality may be applied to conduct within any industry which does not conform to the usual competitive mode of operation. It would be contrary to this Court's prior decisions to apply the *per se* standard of illegality to conduct, regardless of its characterization, when the conduct's effects on competition are unknown or inconclusive.

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[22] *Id.* at 692.

[23] *Id.* at 696.

The health care delivery system presents a unique market situation which deserves a thorough examination of all the facts in order to fairly judge the pro-competitive or anticompetitive effects of the Respondents' activities. For example, in *Virginia Academy of Clinical Psychologists* v. *Blue Shield*,[24] the Fourth Circuit refused to apply a *per se* rule of illegality to medical plans which refuse or condition payments to competing providers.[25] The refusal was based upon the inappropriateness of applying a *per se* standard to the special circumstances inherent in the delivery of health services.[26] The special circumstances present in the health care delivery system have resulted in a marketplace which has not functioned competitively in the classic sense.[27] This fact was recently considered by the Supreme Court in *National Gerimedical Hospital and Gerontology Center* v. *Blue Cross*,[28] in which the Court took special note of a 1974 report of the Committee on Labor and Public Welfare of the United States Senate which stated:

> In the view of the Committee, the health care industry does not respond to classic marketplace forces. The highly technical nature of medical ser-

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[24] 624 F.2d 476 (4th Cir. 1980).

[25] *Id.* at 484.

[26] *Id.* The Court refused to apply the *per se* standard even though the activity in question was characterized as a boycott, activity which is treated as a *per se* violation when encountered in a general commercial context. *Id.*

[27] Miller, *Antitrust and Certificate of Need: Health Systems Agencies, the Planning Act, and Regulatory Capture*, 68 *Geo. L.J.* 873, 876 (1980) [hereinafter cited as *Miller*].

[28] No. 80-802 (Sup. Ct. June 15, 1981)(finding no implied antitrust immunity for the refusal of Blue Cross to grant participating status to National Gerimedical Hospital).

> vices together with the growth of third party reimbursement mechanisms act to attenuate the usual forces influencing the behavior of consumers with respect to personal health services. For the most part, the doctor makes purchasing decisions on behalf of the patient and the services are frequently reimbursed under health insurance programs, thus reducing the patient's immediate incentive to contain expenditures.[29]

The marketplace in which commodities and services are bought and sold is generally described as the typical commercial marketplace. Consumers in this market respond to differences in price and quality and will demand the highest quality at the lowest price. It follows that the buying responses of consumers determine which commodities will be widely produced and indirectly determine the prices at which they will be sold.

Unlike the environment of the typical commercial marketplace, patients (consumers in the health care industry) have generally not responded to changes in price of care, primarily because their health insurance coverage operates to remove price as a factor at the time of delivery of the service. In a 1980 article in *The Georgetown Law Journal,* Frances Miller cited examples of the health insurance benefits and favorable tax treatment for medical expenses which undercut financial incentives that might otherwise lead patients to economize on health care expenditures:

> For calendar year 1978, 67% of total personal health care expenditures in the United States were financed by some form of third-party payment. Pa-

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[29] *S. Rep. No.* 93-1285, 93d Cong., 2d Sess. 39, *reprinted in* [1974] U.S. Code Cong. & Ad. News 7842, 7878; No. 80-802, *slip op.* at 8 (Sup. Ct. June 15, 1981).

> tients did not have to pay out-of-pocket for $112.6 billion of their health care costs. [citation omitted] Health insurance premiums are deductible business expenses. Treas. Reg. §162-10(a) (1975). Moreover, they are not taxed as income to employees. I.R.C. §106. . . . Individual taxpayers who do not receive health insurance benefits from employers, but purchase it directly from insurers, may deduct the first $150 of premiums paid from ordinary income. I.R.C. §213(a)(2). In addition personal medical expenses are deductible from ordinary income to the extent they exceed three percent of adjusted gross income. I.R.C. §213(a)(1).[30]

An additional disincentive to shop for the best price in health and medical care is the high degree of technological complexity involved in their delivery. Medical treatment frequently involves advanced scientific testing and evaluation and few consumers fully understand the differences in the objectives sought or the specific results to be achieved from various methods of treatment. Although cost is often directly related to the technological complexity of the diagnostic and treatment procedures pursued, the need and demand for innovative testing and treatment has resulted in a lessened concern for cost-benefit analysis. Both patients and physicians tend to prefer the more advanced form of treatment, normally believed to be the best, although more costly, alternative.[31] As a result of third-party reimbursement and patient naivete with respect to differences in methods of treatment, the customary effects of price on the marketplace do not occur in the delivery of health services.

In addition to the fact that consumers of health care services fail to respond to price, they also are unable to

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[30] *Miller, supra* note 27, at 877, n. 25.

[31] *See id.* at 877.

adequately respond to the quality or degree of treatment which they receive. Because of the general lack of information and knowledge on the part of consumers regarding the necessity for medical treatment or the type or extent of treatment needed, patients characteristically pursue and accept whatever treatment is recommended by their physician. Consequently, in the health care delivery system, there is no competitive marketplace in the form of a greater demand for the physicians who recommend less treatment at lower prices.

Role of foundations for medical care within the health care delivery system

In an environment which did not respond to normal competitive forces, Foundations for Medical Care were established to monitor the cost and quality of health care. FMCs are best described as corporations of physicians organized under state nonprofit statutes concerned with the quality and cost of medical care.[32]

> Common to all Foundations are three basic beliefs: physicians must retain responsibility and leadership in the design, administration, and delivery of medical services; medical care must be provided at a just and equitable cost to both patient and physician; and peer review conducted by medical society members must be encouraged as an efficient mechanism to insure quality care and to control the rise of medical costs. In addition, a primary function of most Foundations is preserving the traditional mode of rendering medical care-solo fee-for-service prac-

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[32] *See National Ass'n of Blue Shield Plans, Foundations for Medical Care* I-1 (1972) [hereinafter cited as *Foundations for Medical Care*]; C. Steinwald, *Foundations for Medical Care* 1 (*Blue Cross Reports*, Research Series 7, August 1971) [hereinafter cited as *Blue Cross Report*].

tice. Freedom of choice on the part of the physician and patient is stressed in these Foundations along with the necessity of guarding the time-honored physician/patient relationship.[33]

In an effort to achieve the goals of medical cost containment and quality medical care, each FMC establishes minimum standards of care and specific benefits which the Foundation determines to be crucial to the delivery of quality medical care in its area. The FMC then contracts with insurance companies and/or Blue Cross or Blue Shield Plans to underwrite and market this Foundation-sponsored program. Members of the FMC agree to accept the maximum fees that are set by the FMC and to be subject to peer and utilization review by the Foundation.

Comprehensive FMCs have two principal functions: to design and sponsor prepaid health insurance programs and to carry out peer review of the quality of health care. In evaluating the effectiveness of FMCs in carrying out these basic functions, a report published in 1973 stated: ". . . Comprehensive FMCs . . . have many years of experience with intensive peer review, which has produced important savings in medical costs with no decrease, and often appreciable increases, in quality of care." [34] The same author went on to state that comprehensive FMCs provide about the only responsible vehicle available whereby physicians can be reimbursed on a fee-for-service basis and at the same time participate in an organized, cost-effective, high quality health-care delivery system.[35]

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[33] *Blue Cross Report, supra* note 32, at 1.

[34] R. Egdahl, *Foundations for Medical Care*, 288 *New England J. Med.* 491, 493 (1973) [hereinafter cited as Egdahl].

[35] *Id.* at 495.

The Respondent Foundations were established to provide residents of Pima and Maricopa Counties with a competitive alternative to utilization of closed panel prepaid health insurance plans.[36] "The foundations' medical insurance programs provide a unique competitive alternative that directly promotes competition, with demonstrable benefits to insured patients."[37] Patients insured by the Respondent Foundations may be treated by any physician of their choice. If they choose a physician member of the Foundation, the patients are assured that their insurance will cover payment-in-full for their medical treatment. Should Foundation insureds receive treatment from nonmember physicians, the physician is paid the fee set by the FMC for the treatment given, and the physician may then bill the patient for the balance of his charge for the services rendered. This process provides the patient with a procompetitive incentive to shop for a physician who is a member of the Foundation or who does not charge more than the Foundation will pay.

The Respondent Foundations' establishment of maximum reimbursement levels is a critical component of the over-all purpose of the FMCs to provide prepaid health insurance programs and to monitor both the quality and cost of health care. Insurers rely on maximum reimbursement schedules in cost control programs,[38] as does the State of Arizona in determining appropriate

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[36] Joint Brief in Opposition to the State of Arizona's Petition for a Writ of Certiorari at 8, filed October 20, 1980 [hereinafter cited as Respondents' Joint Brief].

[37] *Id.*

[38] D. Kallstrom, *Health Care Cost Control by Third Party Payors: Fee Schedules and the Sherman Act*, 1978 *Duke L.J.* 645, 690 (1978) [hereinafter cited as Kallstrom]; Egdahl, *supra* note 34 at 492, 495.

payments to physicians in, *inter alia,* workmen's compensation cases.[39] In addition, maximum reimbursement schedules are currently used in approximately 25% of Blue Shield contracts.[40] In setting up a prepaid health-service activity,

> some type of control of payment to physicians is necessary, and since the comprehensive FMC is dedicated to the fee-for-service principle of reimbursement, no program can be actuarily sound without agreement by physicians on maximum fees coupled with appropriate peer review to prevent overutilization of treatments and procedures.[41]

Like the blanket license mechanism in *Broadcast Music,* the use of maximum reimbursement levels has provided an acceptable method for accomplishing the principal purposes of the FMCs over the years.[42]

Under the rule established by this Court in *Northern Pac. Ry.* v. *United States* and reaffirmed in *Broadcast Music, Inc.* v. *Columbia Broadcasting System, Inc.* this conduct should not be presumed *per se* violative of the Sherman Act unless there is a "universal view"[43] that the activity in question in anticompetitive without any redeeming virtue. There is no such consensus regarding the challenged conduct within the health care delivery

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[39] Respondents' Joint Brief, *supra* note 36, at 6.

[40] Bureau of Competition, Federal Trade Commission, *Medical Participation in Control of Blue Shield and Certain Other Open-Panel Medical Prepayment Plans,* Staff Report to the Federal Trade Commission and Proposed Trade Regulation Rule, at 128 (April 1979) [hereinafter cited as FTC Staff Report].

[41] Egdahl, *supra* note 34, at 492.

[42] *See* text accompanying notes 32-42, *supra.*

[43] *Broadcast Music, Inc.* v. *Columbia Broadcasting System, Inc.,* 441 U.S.1, 16 (1979).

system. Respondent Foundations argue that they provide a competitive alternative to closed panel prepaid health insurance plans. Whether the procompetitive aspects of their conduct offset the alleged potential anticompetitive impact is an issue of fact which has not yet been determined.

Across the health care delivery system, relationships not unlike those before the Court today are being examined. The results are inconclusive as to whether medical participation in health insurance plans is violative of the antitrust laws. For example, in April, 1979, the Bureau of Competition of the Federal Trade Commission issued a Staff Report and Proposed Trade Regulation Rule ("the Report") entitled *Medical Participation in Control of Blue Shield and Certain Other Open-Panel Medical Prepayment Plans.* The Report provided an in-depth analysis of the Bureau of Competition's investigation into ". . . the extent, impact, and legality of medical participation in the control of Blue Shield and other open-panel medical prepayment plans."[44] The results of the investigation confirmed that physicians and physician organizations often control or influence Blue Shield decisions concerning reimbursement, cost-containment, and other matters affecting competition.[45] The investigation was conducted over a period of more than three years and studied activities involving physicians' influence upon the determination of appropriate reimbursement levels for Blue Shield plans. The conduct under investigation was similar and comparable to that of the FMCs which is before the Court today.

It is noteworthy that the 409-page Report and Proposed Rule were not adopted as an official Federal

[44] FTC Staff Report, *supra,* note 40, at 1.

[45] *Id.*

Trade Commission position. Instead, the Commission requested comments on the conclusions which ranged from a finding that certain activities contributed to the benefit of the public, to the conclusion that some forms of medical participation in the control of Blue Shield and other open-panel medical prepayment plans may constitute unfair methods of competition.[46] After receiving comments on the controversial Report and proposal to limit the control physicians or medical societies have over Blue Shield boards, the FTC recently abandoned plans to promulgate an industrywide rule on the matter.[47] Instead, the Commission will investigate complaints on a case-by-case basis. Because the results of the analysis were far from conclusive as to alleged potential anticompetitive effects of physician control over reimbursement decisions made by Blue Shield boards, the FTC plans to proceed selectively when examining these types of relationships, using the Rule of Reason approach that takes into account the share of the market possessed by a plan, the degree of physician participation in fee setting, the plan's coverage, and any other facts relevant to understanding the competitive effects of the activity in question.[48]

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[46] *Id.*, at 2, 4.

[47] *See* 46 Fed. Reg. 27768 (1981).

[48] *Id. See Michigan State Medical Society*, No. 9129 (FTC June 19, 1981). This is an initial decision in which the FTC relied on this Court's opinions in *National Society of Professional Engineers* v. *United States*, 435 U.S. 679 (1978), and *Goldfarb* v. *Virginia State Bar*, 421 U.S. 773 (1975), as a basis for examining the alleged price-fixing and boycott agreements in dispute according to the Rule of Reason standard of illegality rather than holding them to be *per se* violative of the Sherman Act.

This recent FTC action is persuasive evidence of the inadequate level of knowledge regarding the health care delivery system and the competitive response of this unique industry to various types of business relationships, including those challenged in the case at bar.

IV. Because Of The Unique Nature Of The Health Care Delivery System, The Challenged Activity Should Be Judged According To The Rule Of Reason Standard Of Liability Rather Than According To The Per Se Standard

Courts need considerable experience in evaluating the competitive effects of business relationships in the health care delivery system before the *per se* standard of illegality may be applied.[49] For this reason, the Court should avoid adopting a characterization developed in other commercial contexts for conduct whose competitive effects in the health services industry are inconclusive. Because the inquiry under the Rule of Reason focuses on the competitive impact of conduct, the Rule of Reason is the standard to be applied when the competitive effects of activity in question are unknown.

There is no dispute as to the fact that in the strict commercial context, agreements to fix prices have been held illegal *per se*.[50] The same is true of agreements to

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[49] *See Broadcast Music, Inc.* v. *Columbia Broadcasting System, Inc.*, 441 U.S. 1 (1979); *Continental T.V., Inc.* v. *GTE Sylvania Inc.*, 433 U.S. 36, 50 (1977); *United States* v. *Topco Associates, Inc.*, 405 U.S. 596, 607 (1972); *White Motor Co.* v. *United States*, 372 U.S. 253, 263 (1963).

[50] *See United States* v. *McKesson and Robbins, Inc.*, 351 U.S. 305 (1956) (manufacturer/wholesaler agreed with independent wholesalers on prices to be charged on products it manufactured); *United States* v. *Socony-Vacuum Oil Co.*, 310 U.S. 150 (1940) (firms controlling a substantial part of an industry agreed to purchase

set maximum resale prices in the general commercial field.[51] However, not every agreement which literally determines a price is "price fixing" for purposes of employing the *per se* standard of illegality under the Sherman Act.[52] This Court stated in *Broadcast Music, Inc.* v. *Columbia Broadcasting System, Inc.* that ". . . easy labels do not always supply ready answers" and that a

> . . . literal aproach does not alone establish that this particular practice is one of those types [to which the per se rule has been held applicable] or that it is "plainly anticompetitive" and very likely without "redeeming virtue."
>
> Literalness is overly simplistic and often overbroad. . . . Thus, it is necessary to characterize the challenged conduct as falling within or without that category of behavior to which we apply the label "per se price fixing." That will often, but not always be a simple matter. [Citations omitted].
>
> Consequently, as we recognized in *United States* v. *Topco Associates, Inc.*, 405 U.S. 596, 607-608 (1972), "[i]t is only after considerable experience with certain business relationships that courts classify them as per se violations. . . ."[53]

In *Broadcast Music,* this Court faced the question of whether the issuance by the American Society of

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"surplus" gasoline with the intent and necessary effect of increasing the price); *United States* v. *Trenton Potteries Co.*, 273 U.S. 392 (1927) (manufacturers and distributors of 83% of certain vitreous pottery fixtures agreed to sell at uniform prices).

[51] *See Kiefer-Stewart Co.* v. *Joseph E. Seagram & Sons, Inc.*, 340 U.S. 211 (1951).

[52] *Broadcast Music, Inc.*, v. *Columbia Broadcasting System, Inc.*, 441 U.S. 1, 8-9 (1979).

[53] *Id.*

Composers, Authors and Publishers (ASCAP) and Broadcast Music, Inc. (BMI) to CBS of blanket licenses to copyrighted musical compositions at fees negotiated by them was illegal price fixing as a *per se* violation of the Sherman Act. The Court held that the issuance of the blanket licenses did not constitute price fixing *per se* unlawful under the antitrust laws.[54] While noting that there have been cases holding various licensing practices to be violative of the Sherman Act, this Court found that there was no universal view that the use of the type of license in question (although at established prices) was a form of price fixing subject to automatic *per se* condemnation under the Sherman Act.[55] In so holding, the Court relied on the fact that the blanket license was not merely a naked restraint of trade which had no purpose beyond the stifling of competition.[56] The Court determined that the license in question was a "necessary consequence of the integration necessary to achieve [the efficiencies sought by their use], and a necessary consequence of an aggregate license is that its price must be established."[57]

Only by thoroughly examining all the relevant facts in a case such as the case at bar and *Broadcast Music* can the Court determine whether the conduct at issue violates the Sherman Act. Like the situation facing the Court in *Broadcast Music*, the activity presently before the Court is not at all a naked restraint with no purpose beyond the stifling of competition. The challenged con-

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[54] *Id.* at 24.

[55] *Id.* at 16.

[56] *Id.* at 20 (citing *White Motor Co.* v. *United States*, 372 U.S. 253, 263 (1963)).

[57] *Id.* at 21.

duct is an integral component of the over-all purpose of the FMCs to provide prepaid health insurance programs and to monitor both the quality and cost of health care. As such, ". . . when attacked, it should be subjected to a discriminating examination under the rule of reason. It may not ultimately survive that attack, but that is not the issue before us today."[58]

Petitioner relies on this Court's statement in *Catalano, Inc.* v. *Target Sales, Inc.*,[59] that: "It has long been settled that an agreement to fix prices is unlawful *per se.* It is no excuse that the prices fixed are themselves reasonable."[60] This statement by the Court is not inconsistent with the decision in *Broadcast Music* which recognized the need to have knowledge of the nature of an industry before applying the *per se* standard to conduct within that industry, regardless of whether the conduct could be categorized as that which appears to fit the broad label of "price fixing" or any other characterization.[61] *Catalano* involved general commercial activity with no special circumstances such as those inherent in the health care delivery system. There were no distinct characteristics of the industry in question in *Catalano* which warranted "a more discriminating examination under the rule of reason."[62] The unique

[58] *Id.* at 24.

[59] 446 U.S. 643 (1980).

[60] *Id.* at 647.

[61] *See also Mackey* v. *National Football League*, 543 F.2d 606, 618 (8th Cir. 1976), *cert. dismissed* 434 U.S. 801 (1977); *Virginia Academy of Clinical Psychologists* v. *Blue Shield*, 624 F.2d 476 (4th Cir. 1980).

[62] *Broadcast Music, Inc.* v. *Columbia Broadcasting System, Inc.*, 441 U.S. 1, 24 (1979). This language was used by the Court to define the standard of illegality by which the conduct in question must be judged. *Id.*

nature of the health care delivery system does, however, warrant such an examination of conduct within its realm. The issue is not whether the disputed conduct was reasonable, but rather whether the conduct can be fully and fairly evaluated to determine whether it was reasonable in the context in which it occurred. A decision allowing such an examination is fully consistent with the decisions in both *Catalano* and *Broadcast Music*. In fact, a decision otherwise would be inconsistent with prior opinions because it would brand as illegal *per se* conduct whose competitive effects are as yet unknown.[63]

[63] *See* 46 Fed. Reg. 27768-69 (1981). The FTC reported its conclusion that medical control of prepayment plans is not always anticompetitive and therefore an analysis of the competitive impact of such conduct should include consideration of all relevant facts.

CONCLUSION

For the foregoing reasons, it is respectfully submitted that the judgment of the Court of Appeals should be affirmed. The activities of Respondent FMCs should be evaluated according to the Rule of Reason standard of illegality rather than be classified as *per se* violative of the Sherman Act.

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No. 80-419

In the Supreme Court

OF THE

United States

OCTOBER TERM, 1980

Office-Supreme Court, U.S.
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ALEXANDER L. STEVAS,
CLERK

STATE OF ARIZONA,
Petitioner,

vs.

MARICOPA COUNTY MEDICAL SOCIETY,
MARICOPA FOUNDATION FOR MEDICAL CARE,
and PIMA FOUNDATION FOR MEDICAL CARE,
Respondents.

On Writ of Certiorari to the United States Court of Appeals for the Ninth Circuit

BRIEF OF CALIFORNIA DENTAL SERVICE AS AMICUS CURIAE IN SUPPORT OF RESPONDENTS

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QUESTION PRESENTED

Was the Court of Appeals correct in deciding that the legality under the antitrust laws of reimbursement schedules formulated by Foundations for Medical Care to set the maximum level of reimbursement under Foundation-endorsed health plans could not be determined without consideration of the purposes and competitive effects of such schedules?

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On Writ of Certiorari to the United States Court of Appeals for the Ninth Circuit

BRIEF OF CALIFORNIA DENTAL SERVICE AS AMICUS CURIAE IN SUPPORT OF RESPONDENTS

This brief is filed on behalf of California Dental Service with the written consent of all parties to this proceeding pursuant to Rule 36 of the Court.

INTERESTS OF AMICUS CURIAE

California Dental Service ("CDS") is a California non-profit corporation which undertakes to furnish or pay for the provision of dental services to its subscribers in return for premiums paid by them or on their behalf. Presently, approximately 4.5 million individuals, largely in California,

are covered by CDS dental plans. Under the majority of its plans, CDS agrees to pay the full cost of the dental care provided to its subscribers, minus any deductible or co-payment obligation included in the plan.

To secure dental services for its subscribers, CDS undertakes to pay dentists for services provided to CDS patients so long as those dentists agree to keep their fees below a maximum cap which CDS calculates by evaluating the charges of comparably situated dentists. Thus, CDS functions like other third-party payers providing a service benefit—it sets in advance the price it will pay for health care services and relies on comparative data about provider charges to determine that price. While respondent medical foundations perform the same basic task of setting maximum limits on fee reimbursement, the direct role of providers in determining those limits and the absence of any underwriting or risk-assumption by the foundations themselves clearly distinguish their conduct and its potential effects from that of CDS. Nevertheless, in *Manasen v. California Dental Service,* 1981-1 Trade Cases ¶ 63,959 (N.D. Cal. 1980), a plaintiff class of all California dentists challenged CDS's fee mechanism on the ground that it, too, constituted maximum price-fixing, *per se* illegal under Section 1 of the Sherman Act. In *Manasen,* however, the alleged injury was that dental fees were set at too *low* a level by CDS—precisely the converse of the injury claimed by petitioner here. The application of the maximum price-fixing label to such arguably dissimilar conduct demonstrates the potential spill-over effects of the *per se* rule petitioner seeks. Such a rule, by pretermiting consideration of the competitive impact of the conduct at issue, and fo-

cusing instead on the existence *vel non* of a fee ceiling, threatens to invalidate the legitimate cost-containment efforts of third-party payers along with other types of fee ceilings whose purposes or effects may be less benign. CDS files this brief *amicus curiae* to highlight the difficulties in isolating clearly anticompetitive conduct in the health care market, and the necessity for making a detailed inquiry into actual market impact before such a line reliably can be drawn.

I

SUMMARY OF ARGUMENT

The decision of the Ninth Circuit is fully in keeping with this Court's historical reluctance to apply the *per se* rule to unique and unfamiliar market behavior. For, the conduct at issue here—the formation of maximum reimbursement schedules for use in provider-endorsed third-party payer health plans—is certainly not a "garden variety" restraint of trade, and its competitive effects are neither well-established nor easily predicted. Moreover, the health care market—the context in which respondents' conduct is to be evaluated—deviates dramatically from the conventional market for goods and services which the *per se* rule takes as its benchmark. The special nature of health care services, the prevalence of third-party payers, and the extent of government regulation make this market a peculiar one in which ordinary competitive forces necessarily operate in a weakened manner. The inevitable result is an imperfect fit between the *per se* rule and the aberrant "competitive" regime that obtains in the health care market. For example, the maximum price-fixing label which petitioner wishes to apply to respondents' conduct in order to invoke the *per se*

rule, has also been seized upon by other actors in the health care market to condemn the pro-competitive cost-containment efforts of third-party payers. The Federal Trade Commission, recognizing the unavoidable spill-over effects of any categorical—*per se*—rule when applied to the diverse third-party payment mechanisms operating in the health care market, adopted a more selective rule of reason approach. The sparse record now before this Court certainly supplies no justification for a contrary result.

II

ARGUMENT

Despite petitioner's repeated efforts to treat the Ninth Circuit's decision as either creating a learned professions' exemption to the antitrust laws or repudiating the *per se* rule in price-fixing cases, that decision does neither. Instead, for the court of appeals, like the district court, this case raised only the question of how a particular practice was to be characterized for antitrust purposes. Neither court disputed that the *per se* rule would be the appropriate standard if the challenged practice were ultimately found to constitute price-fixing, but both refused to apply this label without additional evidence as to the purpose and competitive effects of respondents' conduct. And the fact that neither court was familiar with the challenged conduct—the formulation of maximum reimbursement schedules for use by third-party payers—or the market setting in which the conduct occurred materially contributed to this holding.[1]

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[1]The market for health care services and the competitive effects of insurance coverage on that market have rarely been the subject

The reluctance of the courts below to apply the *per se* rule to novel and untested market behavior is fully consistent with the guidance offered by this Court in *Broadcast Music, Inc. v. Columbia Broadcasting System, Inc.* (*"BMI"*), 441 U.S. 1, 9-10 (1979):

> "[A]s we recognized in *United States v. Topco Associates, Inc.*, 405 U.S. 596, 607-608 (1972), '[i]t is only after considerable experience with certain business relationships that courts classify them as *per se* violations . . .' *See White Motor Co. v. United States*, 372 U.S. 253, 263 (1963). We have never examined a practice like this one before; indeed, the Court of Appeals recognized that '[i]n dealing with performing rights in the music industry we confront conditions in copyright law and in antitrust law which are *sui generis*.' 562 F.2d at 132. And though there has been rather intensive antitrust scrutiny of ASCAP and its blanket licenses, that experience hardly counsels that we should outlaw the blanket license as a *per se* restraint of trade."

The Court further stressed that the proper test to be followed in determining whether the conduct at issue is *per se* unlawful, is not whether certain labels such as "price-

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of judicial scrutiny under the antitrust laws. Indeed, prior to the recent decisions in *St. Paul Fire & Marine Ins. Co. v. Barry*, 438 U.S. 531 (1978), and *Group Life & Health Ins. Co. v. Royal Drug Co.* ("Royal Drug"), 440 U.S. 205 (1979), the McCarran-Ferguson Act had been interpreted as exempting the majority of practices in that market from meaningful antitrust challenge. With the scope of the "business of insurance" exemption recently clarified and narrowed, courts are now being presented for the first time with questions touching the operations of markets in which insurance coverage is an indelible feature—a feature fundamentally at odds with the common equations which operate in the traditional competitive markets for goods and services.

fixing" can "literally" be applied, but instead whether injury to competition can in fact be presumed:

> "More generally, in characterizing this conduct under the *per se* rule, our inquiry must focus on whether the effect and, here because it tends to show effect, see *United States v. United States Gypsum Co.*, 438 U.S. 422, 436, n.13 (1978), the purpose of the practice are to threaten the proper operation of our predominantly free-market economy—that is, whether the practice facially appears to be one that would always or almost always tend to restrict competition and decrease output, and in what portion of the market, or instead one designed to 'increase economic efficiency and render markets more, rather than less, competitive.' *Id.*, at 441 n.16; *see National Society of Professional Engineers v. United States*, 435 U.S. at 688; *Continental T.V., Inc. v. GTE Sylvania, Inc.*, 433 U.S. at 50 n.16; *Northern Pac. R. Co. v. United States*, 356 U.S. at 4." 441 U.S. at 19-20 (footnote omitted).

The clear lesson of *BMI*, then, is that before unique and unfamiliar market behavior is branded with the *per se* label, a preliminary inquiry into the purpose and competitive effects of the conduct must be undertaken to determine if the preconditions for application of the *per se* rule have been met. And, as this Court observed in *National Society of Professional Engineers v. United States*, 435 U.S. 679, 696 (1978), such an inquiry is doubly necessary when professional services are involved because "professional services may differ significantly from other business services, and, accordingly, the nature of the competition in such services may vary." The decision of the Ninth Circuit is entirely in keeping with the approach articulated in *BMI* and *National Society of Professional Engineers*, as is its

conclusion that the rule of reason is the proper standard against which the challenged conduct should be tested.[2]

A. The Market for Health Care Services Differs Fundamentally From the Traditional Competitive Marketplace Which Per Se Analysis Takes as Its Benchmark

Among the factors considered by the court below as arguing for application of the rule of reason was the uniqueness of the health care market. Contrary to petitioner's claim, however, this factor was not used by the court to suggest that the reasonableness of fixed prices was a defense to a Sherman Act challenge. Rather, Judge Sneed recognized that the special characteristics of the health care market may bear on the question of whether the maximum reimbursement schedules adopted by respondents "would always or almost always tend to restrict competition," *BMI*, 441 U.S. at 19-20—the essential question in determining if the practice at issue should be *per se* unlawful.[3]

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[2]"The traditional framework of analysis under § 1 of the Sherman Act is familiar and does not require extended discussion. Section 1 prohibits '[e]very contract, combination . . ., or conspiracy, in restraint of trade or commerce.' Since the early years of this century a judicial gloss on this statutory language has established the 'rule of reason' as the prevailing standard of analysis." *Continental T.V., Inc. v. GTE Sylvania Inc.*, 433 U.S. 36, 49 (1977).

[3]Petitioner repeatedly argues that only the challenged conduct of respondents—not its market setting—should be considered in determining if the *per se* rule is applicable. Such a narrow compass for antitrust analysis finds no support in logic or in the prior decisions of this Court. *See, e.g., BMI, supra*, 441 U.S. at 20 ("ASCAP and the blanket license developed together out of the practical situation in the marketplace. . . ."); *National Gerimedical Hospital and Gerontology Center v. Blue Cross of Kansas City and Blue Cross Association*, 49 U.S.L.W. 4672, 4676 n.19 (June 15, 1981)

The special characteristics of the health care market are, in the first instance, a consequence of the unique nature of health care services and the attitudes of patients and providers regarding those services. Unlike a normal consumer, a purchaser of health care typically does not select the services he receives. Rather, entry into the health care market is usually a response to a set of symptoms or complaints from which one seeks relief, with the provider making the determination of which services are required. The consumer does not necessarily even select the provider of the services, but instead is often referred to a specialist by another provider. Thus the consumer, because he does not know in advance what services he is purchasing or who will provide those services, is unable to make meaningful price comparisons.[4] More, the absence of widespread price advertising deprives the consumer of the information necessary to choose among the options in those limited circumstances where a choice is possible and thus further limits the potential for price competition in this market.[5]

The difficulties the consumer has in comparing the prices of health care services offered by "competing" providers are compounded by the fact that fees for particular serv-

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(lower courts should "give attention to the particular economic context in which the alleged conspiracy and 'refusal to deal' took place.").

[4]Of course, when emergency treatment is rendered, the patient's ability to select the range of services or the provider is reduced even further, and economic considerations are subordinated to concerns for the preservation of life or alleviation of pain.

[5]*See* Conrad & Emerson, *State Dental Practice Acts: Implications for Competition*, 5 Journal of Health Politics, Policy and Law 610 (1981); Benham, *The Effect of Advertising on the Price of Eyeglasses*, 15 Journal of Law and Economics 337 (1972).

ices are frequently not the major determinants of overall health care costs. Rather, the course of treatment or intensity of care may have a far more significant influence on the amount which the patient or his insurer will ultimately have to pay. Different physicians may prescribe very different courses of treatment for the same condition, depending on their perception of the patient's needs and their overall approach or therapeutic philosophy. Yet, patients are generally unaware of treatment options and rarely select one provider over another on this basis. The ability of a provider to effect the demand for and utilization of his services further serves to distinguish the market for health care services from the typical competitive market.

The special relationship between the health care provider and the patient also limits the role played by price in this market. Health care consists not simply of discrete services purchased separately as needed, but instead of a series of related and personal services extending over a considerable period of time. Many consumers are, as a result, reluctant to select new providers mid-stream because of a perceived relationship between continuity and quality of care. This characteristic of health care makes consumer shopping for a better price a rare phenomenon in the health care market as does the widespread perception—in part fostered by government policy—that good health is a fundamental right not to be valued in economic terms.[6]

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[6]*See* National Health Planning and Resources Development Act of 1974, § 2, 42 U.S.C. § 300K(a)(1).

The extent of government involvement in and regulation of the health care market—including efforts both to restrict the supply of services and to influence the prices of such services—also distinguishes this market from the markets for most other goods and services. State laws mandating the licensing of both professional and institutional health care providers are an obvious restriction on entry into the market as are state and federal restrictions on capital expenditures for new health care facilities.[7] And, for the more than one-third of personal health care expenditures paid by the government,[8] there are also direct controls on fee levels as well as on the volume of services provided. Specifically, both the federal Medicare program and the federal-state Medicaid program impose ceilings on fees charged to covered patients.[9] To the extent such ceilings influence the overall level of provider charges, their effects are not necessarily limited to the publicly financed segment of the market.[10] Further, the Professional Standards Review Organizations, established by federal law, directly limit the volume of health care services financed, in whole or in part, by public funds.[11]

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[7]*See National Gerimedical Hospital and Gerontology Center v. Blue Cross of Kansas City and Blue Cross Association, supra.*

[8]Health Insurance Institute, *Source Book of Health Insurance Data, 1979-80,* 58, citing U.S. Department of Health and Human Services, Health Care Financing Administration, *Health Care Financing Review,* Summer 1979.

[9]*See* Pub.L. 89-97, 42 U.S.C. §§ 1395u, 1395f(h), 1395cc (Medicare); Pub.L. 89-97, 42 U.S.C. § 1396(b)(i)(1) (Medicaid).

[10]*See* Kallstrom, *Health Care Cost Control By Third Party Payers: Fee Schedules and the Sherman Act,* 1978 Duke L. J. 645, 650; Frech and Ginsburg, *Imposed Health Insurance in Monopolistic Markets: A Theoretical Analysis,* 13 Econ. Inquiry 55, 67-69 (1975).

[11]*See* Pub.L. 92-603, Title II, 42 U.S.C. §§ 1320c-1 *et seq.*

The introduction of insurance into the market for health care services further distorts the interplay of normal competitive forces.[12] The reason requires little explanation: widespread insurance coverage[13] shifts the cost of health care services from the consumer of those services to third-party payers. At the time treatment is rendered, an insured patient pays, at most, only a fraction of the actual cost and thus has little financial incentive to question either the need for or the value of such treatment. The existence of health insurance—often paid for by employers—not only makes the patient less concerned about the cost of any particular medical or dental service, but also increases his or her demand for additional and perhaps more expensive care. Thus, at the point of contact between the provider and the patient, normal price constraints on the behavior of either simply fail to operate. *Cf. National Gerimedical Hospital and Gerontology Center v. Blue Cross of Kansas City and Blue Cross Association, supra,* 49 U.S.L.W. at 4676 (reference to Congressional view that "the health care industry does not respond to classic marketplace forces.")

Instead, to the extent competitive behavior is present at all in the health care market, it results from the bargaining between third-party payers and the providers of health

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[12]*See, e.g.*, Dyckman, *A Study of Physicians' Fees*, Council on Wage and Price Stability 14-21 (1978); Enthoven, *Consumer Centered vs. Job-Centered Health Insurance*, 57 Harv. Bus. Rev. 141 (1979).

[13]In 1978, third-party payments for health care by private health insurers and the government constituted some two-thirds of the total amount spent for personal health care services. Health Insurance Institute, *Source Book of Health Insurance Data, 1979-1980, supra*, at 58.

care services. *See, e.g., United States v. American Soc. of Anesthesiologists,* 473 F. Supp. 147, 160 (S.D.N.Y. 1979). Unlike traditional market transactions, here the ultimate consumer may select the seller but does not bargain with him over price; rather, a surrogate buyer with arguably different interests and incentives—the third-party payer—does what negotiating there is. The peculiarities of this transaction and the regulatory regime in which it takes place yield a competitive order which simply cannot be assumed to duplicate that found in more traditional markets where the *per se* rule has characteristically been applied. Yet, it is in terms of this atypical and unfamiliar market setting, not the idealized model of perfect competition, that respondents' conduct must be judged to determine if it "would always or almost always tend to restrict competition . . ." *BMI, supra,* 441 U.S. at 19-20.

Although the dynamics and competitive consequences of the tri-partite health care transactions described above have not been examined in detail, several key elements or aspects can be identified from the available literature.[14] Clearly, the impulse for price competition in this market—to the extent it exists at all—comes from the insurance company or other third-party payer. In theory, at least, any third-party payer able to reduce its payments to providers can secure an advantage over its competitors by reducing its premiums. Such cost-containment efforts

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[14] *See, e.g.,* Carlson, *Prepaid Prescription Drug Plans Under Antitrust Scrutiny: A Stern Challenge to Health Care Cost Containment,* 75 Nw L. Rev 506 (1980); Havighurst, *Controlling Health Care Costs—Strengthening the Private Sector's Hand,* 1 Journal of Health Politics, Policy and Law 471, (1977).

by insurers—the mechanism through which price consciousness is introduced into the market—depend, however, on the negotiation in advance of an agreement with "participating" providers setting limits on the level of reimbursement.[15] Yet, the reported cases, *see, e.g., Group Life and Health Insurance Co. v. Royal Drug Co., supra; Manasen v. California Dental Serv., supra,* indicate that such agreements have been challenged on maximum price-fixing grounds under *Kiefer-Stewart Co. v. Joseph E. Seagram & Sons, Inc.*, 340 U.S. 211 (1951), *Albrecht v. Herald Co.*, 390 U.S. 145 (1968) and their various progeny. The apparent collision between the doctrine enunciated in *Kiefer-Stewart* and *Albrecht* and the procompetitive cost-containment efforts of third-party payers is a disturbing one. At the very least, it raises questions about the appropriateness of treating maximum price-fixing as a *per se* offense in a context where maximum restraints may be an indispensable ingredient of competitive conduct. *See* Halper, *The Health Care Industry and the Antitrust Laws: Collision Course?*, 49 Antitrust L. J. 17, 27-28 (1981).

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[15] *See, e.g.*, Havighurst, *Professional Restraints on Innovation in Health Care Financing*, 1978 Duke L. J. 303, 326-27; Kallstrom, *Health Care Cost Control by Third Party Payers: Fee Schedules and the Sherman Act, supra.*

B. The Maximum Reimbursement Schedules Developed by Respondents Are Not "Naked Restraints of Trade With No Purpose Except Stifling of Competition" and Thus Should Be Evaluated Under the Rule of Reason Not the Per Se Rule

The unique nature of the alleged restraint of trade at issue here—the formulation of maximum reimbursement schedules for use in provider-endorsed health plans—and the unfamiliarity of the courts with it further weakens the argument for *per se* illegality. Originally, respondents utilized relative value schedules ("RVSs") and conversion factors which, when used in conjunction, yielded a schedule of maximum payments to be made by foundation-endorsed plans.[16] The difficulty of analyzing the competitive impact of RVSs has been aptly noted by Professors Havighurst and Kissam:

> "Due to the unusual market circumstances in which RVSs are produced and used, they are not easy to characterize for purposes of antitrust analysis."

Havighurst and Kissam, *The Antitrust Implications of Relative Value Studies in Medicine*, 3 Journal of Health Politics, Policy and Law 48, 63 (1979).

First, the purposes of such schedules do not neatly fit into the *per se* price-fixing mold. As even the most vehement critics of RVSs concede:

> "[T]here is some reason to doubt that a traditional price-fixing purpose has been a prime motive behind professionally sponsored RVSs. . . . With reliable sub-

[16]Since the commencement of this litigation, respondents have significantly altered the mechanism followed in determining maximum reimbursement levels for foundation-endorsed health plans.

> stitutes for their services difficult to come by and price competition so attenuated, physicians generally would seem to possess substantial monopoly power and probably feel little need to use RVSs as formulas to make higher prices possible. While firmer conclusions than this about competition among physicians probably cannot be drawn, it does seem unlikely that use of the RVS as a price-fixing formula is an important ingredient in their market power."

Havighurst and Kissam, *supra*, at 55-56. Certainly nothing in this record demonstrates that respondents pressured or forced individual physicians into charging similar fees or adhering to the pricing formula set out in the foundations' schedules. Rather, the central purpose of these schedules was to facilitate physician input into the reimbursement and cost-containment decisions of third-party payers. And, once again, there is no evidence in this record to show that third-party payers were coerced into accepting respondents' maximum reimbursement levels, that foundation members were precluded from dealing with non-endorsed health plans or that the market power of the foundations in fact curbed third-party payers' freedom of action.[17] Absent such

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First, relative value schedules and conversion factors play a substantially reduced role in the process, and, second, foundation members no longer vote on the maximum reimbursement schedules. The analysis, *infra*, responds directly to petitioner's criticism of relative value schedules and conversion factors, but applies with equal if not more force to the new procedures adopted by respondents.

[17]The record contains no expert opinion regarding the economic effects of respondents' conduct nor, more significantly, is there evidence from third-party payers about the nature of their dealings with the foundations or their use of the maximum reimbursement schedules. Simply put, the record provides little more than a de-

evidence, efforts by providers to participate in the determination of maximum insurance reimbursement levels do not seem so patently unreasonable or anticompetitive as to warrant *per se* treatment. Petitioner's rigid adherence to the outmoded notion that all contacts among competitors touching on price are necessarily nefarious and therefore *per se* unlawful accounts for its failure to recognize that other legitimate purposes may also motivate such conduct. *See generally, BMI, supra.*

The market effects of the conduct challenged here are equally uncertain and thus defy *per se* treatment. At base, petitioner seems to contend that the promulgation of maximum reimbursement schedules by providers inevitably serves to inflate the overall level of physician fees. Yet, the available evidence suggests that any link between such conduct and actual charges is far too attenuated to support the categorical prohibition which petitioner seeks. Again, addressing this contention in the context of RVSs, Professors Havighurst and Kissam observed that:

> "Although it would seem that an insurer's adoption of a widely distributed RVS as the basis for its maximum fee screen could easily have the same effect [of allowing physicians to submit claims at the maximum level], a recent study of California RVSs found wide

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scription of the practices of the foundations derived from interrogatory responses and requests for admission. No effort has been made to identify or grapple with the economic effects of the challenged conduct; rather the courts below were asked to assume the worst and then to categorically prohibit the challenged conduct. The inadequacies of the record provided a sufficient basis for the denial of petitioner's summary judgment motion, and render this case, in its present posture, an unsatisfactory vehicle for determining the proper antitrust characterization of respondents' conduct.

> disparity among fee claims submitted to Blue Shield for similar services. Another study of physician's pricing behavior on a statewide basis in twenty-four states also found little evidence that physicians adhere rigorously to RVSs in pricing their insured services. It thus appears that physicians may not have used RVSs systematically to set their fees at maximum reimburseable levels. Perhaps, given the theoretical possibility, this must be regarded as an instance of physicians' departure from the economists' norm of profit maximization."

Havighurst & Kissam, *supra* at 56-57. Much the same conclusion was reached in a recent economic analysis of RVSs:

> "The primary implication that may be drawn from these results is that, while use of a RVS is associated with lower fee dispersions, a RVS does not lead directly to higher fee levels. Combined with the results on insurers, these results provide strong evidence that greater use of RVSs is primarily related to the prevalence of third parties, and that use of RVSs has had no significant positive effect on reimbursement levels. Further, there is some evidence to indicate that use of RVSs in association with third parties may result in limiting reimbursement levels to physicians."

Eisenberg, *Information Exchange Among Competitors: The Issue of Relative Value Schedules for Physician Services*, 23 Journal of Law and Economics 441, 457 (1980).[18] Simply put, the impact of maximum reimburse-

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[18]It is important to distinguish between a reduction in fee dispersion and an increase in average fee levels. While the latter, if the result of contact among competitors, may constitute price-fixing, the former is generally regarded as an indication of market efficiency and the availability of information regarding competitive con-

ment schedules on physician price behavior confounds easy prediction thereby rendering reliance on the *per se* rule literally a "hit or miss" proposition.

Moreover, the absence of any evidence in this record from third-party payers about the nature of their relationship with the respondent foundations is particularly disturbing. For, the competitive effects of respondents' conduct may depend on whether third-party payers play an active role in reimbursement decisions or instead passively accept whatever level of fees respondents suggest. Indeed, in its study of physician control of third-party payers, the FTC's Bureau of Competition concluded that "to the extent [foundations] must negotiate at arm's length with independent underwriters over the terms on which coverage will be offered to subscribers," an effective check may be placed on the anticompetitive effects generated by "provider control" in other contexts. FTC Bureau of Competition, Staff Report, *Medical Participation in Control of Blue Shield and Certain Other Open-Panel Medical Prepayment Plans* 332-33 (April 1979). In all events, questions about the market behavior of insurers when faced with

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ditions. Consumer search behavior is one mechanism whereby such information is gathered and communicated in the normal market setting; an alternate method is the exchange of price information among producers or providers. Particularly in the health care market where consumer "shopping" is infrequent, exchange of pricing information through RVSs or in some other fashion may be the only available method for disseminating such data and thereby eliminating the "pockets of glut and shortage" that a wide dispersion of fees or prices may yield. *See generally*, Posner, *Information and Antitrust: Reflections on the Gypsum and Engineers Decisions*, 67 Geo. L. Rev. 1187 (1979).

provider-generated maximum reimbursement schedules are empirical ones which can only be answered after an evidentiary inquiry of precisely the type prohibited by the *per se* rule.

C. The Recent Decision of the FTC Not to Promulgate an Industrywide Rule Barring Physician Control of Third-Party Payers Provides Additional Justification for the Decision Below

In 1979, the Federal Trade Commission's Bureau of Competition released the results of its study of the involvement of physicians in the governance and administration of open-panel medical prepayment plans. FTC Bureau of Competition, Staff Report, *Medical Participation in Control of Blue Shield and Certain Other Open-Panel Prepayment Plans, supra,* ("Medical Participation"). That study and an accompanying economic analysis by the FTC's Bureau of Economics, Kass & Paulter, *Physician Control of Blue Shield Plans* (November 1979), reached the conclusion that:

> "[M]edical participation in the control of many Blue Shield plans is sufficiently great that physicians and physician organizations are able to control or influence economically significant decisions made by the plans. These decisions concerned how much to pay physicians, whether or not to pay non-physician health professionals who compete with physicians, what cost-containment mechanisms to employ and other matters that affect competition in the professional health services section of the nation's economy."

Medical Participation, supra, at 1. The study also concluded that foundation-sponsored health plans, like those

endorsed by respondents here, raised related, if not identical, antitrust issues to those raised by physician control of Blue Shield. *Id.* at 306-07.

As a remedy for the anticompetitive conduct which it identified, the Bureau recommended an industrywide rule barring, *inter alia,* direct or indirect control of open-panel medical payment plans by any physician organization on the ground that such control constituted an unfair method of competition under Section 5 of the FTC Act. The scope of the proposed rule was intended to be quite broad covering:

> "All open-panel plans—including medical service bureaus, FMC's [Foundations for Medical Care] and IPA-type HMO's—because medical control of all such plans apparently involves joint fee-setting activity by physicians who otherwise compete with each other."

Id. at 330. *See* 45 Fed. Reg. 17,019 (March 17, 1980) (initial request for comments on proposed rule-making).

Comments on the staff's recommendation and further studies undertaken by the General Accounting Office and the FTC Bureau of Economics,[19] however, raised doubts that the nexus between physician involvement in pre-paid health plans and higher levels of physician reimbursement was as direct and inevitable as the staff's request for rule-making—essentially a *per se* approach—had suggested. Instead, those comments and studies persuaded the Commission that:

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[19]General Accounting Office, *Public Representation On Boards And Blue Shield Allowances: Important Relationships Not Found* (1980); Anderson, Kass & Pautler, *Physician Control of Blue Shield Plans: A Further Discussion of the Issues* (1981).

> "[I]ndustrywide rule-making is not the appropriate way to address these concerns. Rule-making does not appear to be the most appropriate remedy, because the Commission has concluded that medical control of prepayment plans is not always anticompetitive despite the potential for abuse, and because *it may not be feasible to devise a rule that clearly distinguishes between procompetitive and anticompetitive agreements.* . . ."

46 Fed. Reg. 27768-69 (May 21, 1981) (emphasis added). The Commission went on to note that analysis of the competitive impact of agreements between physicians and third-party payers would involve consideration of a broad range of factors including:

> "the purpose behind the agreement; the type of physician group involved; the market power of the plan and physician group; the extent of control exercised by the group; the particular practices adopted by the controlled plan and their effects on price, coverage and other competitive factors; and any procompetitive business justifications for such plan practices."

Id.

In sum, the FTC, after a detailed study and analysis of the competitive consequences of provider control of third-party payers by, *inter alia,* foundations like respondents here, rejected the *per se* approach which petitioner—on the strength of a far less adequate record—now urges this Court to adopt. Rather the Commission, recognizing the peculiarities of the market setting and the fee mechanisms involved, chose to apply the rule of reason and consider the competitive effects of the various reimbursement mechan-

isms at issue.[20] *See* Statement of FTC Commissioner David A. Clanton *reprinted in* CCH Trade Regulation Reports No. 487, p. 9 (April 27, 1981) (Economic studies and other factors "emphasize the need to proceed in a more selective fashion, using a rule of reason approach.") While the FTC's determination is, of course, not binding on this Court, its conclusion—reached after a detailed and wide-ranging investigation—cannot be ignored in analyzing respondents' practices. *Cf., BMI, supra,* 441 U.S. at 13. For the FTC's adoption of the rule of reason approach stands as a direct refutation of petitioner's claim that conduct like that of the respondents here inexorably and ineluctably restrains competition.

Moreover, the FTC's discriminating approach to regulation in this area reflects the difficulty of attempting to apply a categorical rule to the variegated third-party payer mechanisms operating in the health care market. As the reported cases illustrate, the perceived economic effects of these mechanisms differ dramatically depending on the vantage point from which they are surveyed. For example, in *Royal Drug, supra,* high cost pharmacies contended that the maximum cap on reimbursement levels reflected predatory conduct by the insurer and lower cost pharmacies to force them out of the market. In the instant case, by contrast, petitioner argued that providers were

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[20]The recent decision in *Michigan State Medical Society,* Trade Reg. Rep (CCH) ¶ 21,836 (FTC June 30, 1981), exemplifies this approach. There the administrative law judge—after considering the *competitive effects* of the Medical Society's efforts to regulate the reimbursement policies of Blue Cross, Blue Shield and Medicaid—concluded that the antitrust laws had been violated.

imposing high-cost reimbursement schedules on the third-party payers to the detriment of the consuming public. In *Manasen, supra,* it was the providers who complained that the third-party payers conspired with their subscribers to impose lower fee ceilings on them. And in *Travelers Insurance Co. v. Blue Cross of Western Pennsylvania,* 481 F.2d 80 (3d Cir. 1972), *cert. denied,* 414 U.S. 1093 (1973), a competing insurer alleged that Blue Cross—by imposing a limit on payments for services rendered to its subscribers—was gaining an unfair competitive advantage over other third-party payers. Yet in all four cases, the same basic antitrust issue was raised—the status of maximum limits on fees or reimbursement levels under Section 1 of the Sherman Act.

It is thus apparent that in this special market setting, labels will not substitute for analysis. Institutional factors like the nature of the market for health care services, the extent of competition among insurers, the market power of such insurers, and the nature and scope of provider control of these insurers must be analyzed before the competitive impact of any particular fee-setting mechanism can be determined. Given the capacity of the *per se* doctrine to strike down the benign in the quest for judicial efficiency and guidance, that doctrine should be employed only when experience teaches that the risk of error is *de minimis.* This record and the judiciary's limited exposure to market behavior like that of respondents do not provide the experience required to make that judgment here.

CONCLUSION

For the foregoing reasons, the decision of the Ninth Circuit should be affirmed.

Dated: August 4, 1981

Respectfully submitted,
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(Appendix follows)

APPENDIX

Attorney General [Letterhead]
State Capitol
Phoenix, Arizona 85007

Robert K. Corbin

April 7, 1981

Robert A. Rosenfeld, Esq.
Heller, Ehrman, White & McAuliffe
44 Montgomery Street
San Francisco, California 94104

Re: State of Arizona v. Maricopa County Medical Society, No. 80-419

Dear Mr. Rosenfeld:

This letter is in response to your request of March 31, 1981, for consent to the filing of an amicus curiae brief by the California Dental Service on behalf of the respondents in the referenced case. The State of Arizona has no objection and hereby consents.

Very truly yours,
ROBERT K. CORBIN
Attorney General

/s/ CHARLES L. EGER
CHARLES L. EGER
Assistant Attorney General
Antitrust Division

Brown & Bain [Letterhead]
A Professional Association
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Phoenix, Arizona 85001
(602) 257-8777

April 2, 1981

State of Arizona v.
Maricopa County Medical Society

Dear Mr. Rosenfeld:

Confirming our telephone conversation, I am authorized on behalf of all respondents to confirm that they have no objection to California Dental Service filing a brief *amicus curiae* in the above-captioned matter.

With respect to the briefing schedule, the parties have agreed that petitioner's brief and the joint appendix may be filed by June 5, 1981 and respondents' briefs by August 24, 1981. Of course, the foregoing is subject to approval by the Court.

Please feel free to call me if you have any further questions about the case. I hope that we will have an opportunity to get together in the near future.

Yours truly,

/s/ PHILIP P. BERELSON
Philip P. Berelson

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NO. 80-419

Office-Supreme Court, U.S.
FILED
JUN 5 1981
ALEXANDER L. STEVAS,
CLERK

IN THE

Supreme Court of the United States

OCTOBER TERM, 1980

STATE OF ARIZONA,

Petitioner,

VERSUS

MARICOPA COUNTY MEDICAL SOCIETY, MARICOPA FOUNDATION FOR MEDICAL CARE, and PIMA FOUNDATION FOR MEDICAL CARE,

Respondents.

ON WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE NINTH CIRCUIT

BRIEF FOR CHALMETTE GENERAL HOSPITAL, INC., THIAN & COMPANY, MONTELEPRE MEMORIAL HOSPITAL AND ST. CHARLES GENERAL HOSPITAL AS *AMICUS CURIAE*

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NO. 80-419

IN THE
SUPREME COURT OF THE UNITED STATES

OCTOBER TERM, 1980

STATE OF ARIZONA,

Petitioner,

VERSUS

MARICOPA COUNTY MEDICAL SOCIETY,
MARICOPA FOUNDATION FOR MEDICAL CARE, AND
PIMA FOUNDATION FOR MEDICAL CARE

Respondents.

ON WRIT OF CERTIORARI TO THE UNITED STATES
COURT OF APPEALS FOR THE NINTH CIRCUIT

BRIEF FOR CHALMETTE GENERAL HOSPITAL, INC., THIAN & COMPANY, MONTELPRE MEMORIAL HOSPITAL, AND ST. CHARLES GENERAL HOSPITAL AS AMICUS CURIAE

QUESTION PRESENTED

Whether an agreement among competing physicians setting the maximum prices they will charge insurance companies for services provided to insured patients is illegal per se under Section 1 of the Sherman Act.

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BRIEF FOR CHALMETTE GENERAL HOSPITAL, INC., THIAN & COMPANY, MONTELPRE MEMORIAL HOSPITAL, AND ST. CHARLES GENERAL HOSPITAL AS AMICUS CURIAE 1/

SUMMARY OF ARGUMENT

The decision of the Ninth Circuit is contrary to established law. The fact that the agreements under scrutiny are related to the health care industry does not mandate application of rule of reason analysis to business arrangements which have historically been subject to the *per se* rule. The decision of Ninth Circuit will create tremendous uncertainty in commercial transactions related to the health care industry and will obstruct enforcement of the antitrust laws.

1/ This Brief is submitted on behalf of three small New Orleans hospitals which have brought suit for damages and injunctive relief against Blue Cross [Louisiana Health Service & Indemnity Company] and ten New Orleans hospitals, including the largest hospitals in the area, alleging violations of various provisions of the federal antitrust statutes. Plaintiffs have challenged the validity of the so-called provider agreements, under which defendant Blue Cross fully reimburses the larger hospitals and discriminatorily reimburses the plaintiff hospitals for providing identical medical services to Blue Cross policyholders. Plaintiffs allege that the reimbursement agreements constitute price fixing. The complaints also challenge the conspiracy and monopolistic practices which created the dual systems for reimbursement. *Chalmette General Hospital, Inc., et al. v. Louisiana Health Service & Indmenity Co., et al.*, Civil Action 78-1875 and consolidated cases, United States District Court for the Eastern District of Louisiana.

ARGUMENT

This brief is submitted in support of the petition of the State of Arizona. It is submitted that this Court should reverse the decision of the Ninth Circuit Court of Appeals and hold that an agreement among competing physicians which sets the maximum prices to be charged insurance companies violates *per se* Section 1 of the Sherman Act, 15 U.S.C. §1. The holding of the Ninth Circuit, based on two separate opinions comprising the majority, represents a far-reaching departure from established principles of antitrust law.

The Ninth Circuit acknowledged that price fixing agreements are so lacking in redeeming virtue, that they are usually classified as *per se* unreasonable. "Once so classified a violation of the Sherman Act is made out merely by proving that such an unworthy agreement exists. Actual proof of its competitive impact is unnecessary. It is presumed to be anticompetitive." *Arizona v. Maricopa County Medical Society*, 1980-81 Trade Cases (CCH) ¶63,239 at 78,154.

The court of appeals noted, however, that "this record reveals nothing about the actual competitive effect of the challenged arrangement nor do the authorities, primary or secondary, afford assurance concerning its competitive impact." *Arizona v. Maricopa County Medical Society, supra* at 78,154.

Both of the majority opinions "drew comfort from the Supreme Court's reiteration in *National Society of Professional Engineers*, 435 U.S. at 696, n. 22, of its statement in *Goldfarb v. Virginia State Bar*, 421 U.S. 773 (1975), that marketing restraints that regulate professional competition may pass muster under the Rule of Reason even though similar restraints on ordinary business competition would not." *Arizona v. Maricopa County Medical Society, supra* at 78,157. However, in these two cases, this Court in fact held that price fixing by engineers and lawyers is *per se* unlawful. These decisions do

not require the application of the rule of reason analysis to *per se* violations just because professional conduct is involved. The quoted language merely means that certain "market restraints" (other than price fixing) may pass muster under the rule of reason, because of the professional relationships involved. This language merely notes that certain types of professional business restraints may be reasonable under rule of reason analysis; this language should not be interpreted as converting *per se* illegality involving professionals into a question of "reasonableness".

When the issue presented is whether or not agreements fix prices and are therefore illegal *per se*, it is neither relevant nor necessary to determine the competitive impact of the agreements. The initial determination is whether or not the challenged agreements fall within one of the categories of *per se* violations. Only after an agreement is determined not to fall within one of those categories is an examination of its competitive impact necessary or proper.

In *United States v. Socony-Vacuum Oil Company, Inc.*, 310 U.S. 150 (1940), this Court made it clear that power to fix prices may be found to exist even though the combination does not control a substantial part of the market. "Price fixing agreements may have utility to members of the group though the power possessed or asserted falls far short of domination and control." *United States v. Socony-Vacuum Oil Company, Inc.*, at 224.

There is no requirement in the antitrust laws that there be a wrongful increase in fees to establish price fixing and a *per se* violation. First, any agreement which affects prices in any manner is illegal *per se*. *Socony-Vacuum, supra*. Second, in *United States v. Addyston Pipe & Steel Company*, 175 U.S. 211 (1899), and in subsequent Supreme Court decisions, it is well-settled that the reasonableness of the prices set by private agreement is not a defense. See also, *United States v.*

Trenton Potteries Company, 273 U.S. 392 (1927). 2/ Third, in *Kiefer-Stewart Company v. Joseph E. Seagram & Sons, Inc.*, 340 U.S. 211 (1951), the Court held that an agreement fixing maximum resale prices among competitors violated the Sherman Act as much as those agreements fixing minimum prices. It is irrelevant whether or not the challenged agreements resulted in an increase in prices.

This Court reaffirmed the *per se* rule last year in *Catalano, Inc. v. Target Sales, Inc.*, 446 U.S. 643 (1980). If an agreement is determined to be any "form of price fixing, and since price-fixing agreements have been adjudged to lack any 'redeeming virtue', it is conclusively presumed illegal without further examination under the rule of reason." *Catalano, Inc., supra* at 650.

The Ninth Circuit gave "lack of experience" in the health care field as a reason for its reluctance to find a *per se* violation of the antitrust laws, citing *Broadcast Music, Inc. v. Columbia Broadcasting System*, 441 U.S. 1 (1979).

The Ninth Circuit's reliance on *Broadcast Music* is misplaced because of the uniquely different facts presented. The activities

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2/ "The reasonable price fixed today may, through economic and business changes, become the unreasonable price of tomorrow. Once established, it may be maintained unchanged because of the absence of competition secured by the agreement for a price reasonable when fixed. Agreements which create such potential power may well be held to be in themselves unreasonable or unlawful restraints, without the necessity of minute inquiry whether a particular price is reasonable or unreasonable as fixed and without placing on the government in enforcing the Sherman Law the burden of ascertaining from day-to-day whether it has become unreasonable through the mere variation of economic conditions." *Id.*, 397-398.

alleged to be illegal in *Broadcast Music* involved extensive governmental regulation, "practical problems peculiar to the market for musical compositions" and "a highly unusual fact situation". *National Constructors Association v. National Electrical Contractors Association, Inc.*, 498 F. Supp. 510, 536-537 (D. Md. 1980). "*Broadcast Music* . . . arose in a 'unique context,' characterized by 'the lower court's continuing scrutiny and control of defendants' activities,' 'the approving position of the Department of Justice,' 'the indirect approval of blanket licensing by Congress in the new Copyright Act,' and 'the need for the two organizations and the efficiency of blanket licensing.' " *United States v. Columbia Pictures Industries, Inc.*, 1980-81 Trade Cases (CCH) ¶63, 698 (S.D.N.Y. 1980) at 77,754. *Broadcast Music* was concerned with whether the agreement was in fact price fixing, and not whether price fixing is subject to rule of reason analysis. A court's initial difficulty may be in making a determination that price fixing is involved. However, once the court determines that price fixing has occured, the inquiry is at an end.

It is submitted that price fixing in so basic an industry as health care should be subject to the *per se* rule. It would be most unfortunate if any further exceptions were imposed on the health care industry in view of the imperfections in the nature of competition which already presently exist in that industry. However, if the Court should feel that the health care industry warrants special analysis, a distinction could be made between those agreements which directly involve the professional relationship, and those agreements which involve commercial aspects and which only indirectly involve the professional relationship. If rule of reason analysis is in any way applicable to professional restraints, in lieu of *per se* treatment, it should apply only when truly professional considerations are presented.

Such distinctions are common in antitrust analysis of business agreements. For example, in *Group Life & Health Insurance Company v. Royal Drug Company*, 440 U.S. 205

(1979), this Court distinguished contracts which are the "business of insurance" from contracts involving "insurance business". Furthermore, this Court long ago recognized that it is often necessary to judge a contract by what it accomplishes in fact rather than by the name which is assigned to it. ***Appalachian Coals, Inc. v. United States,*** 228 U.S. 344 (1933). Similarly, different standards may be applicable in considering contracts which regulate professional conduct from contracts which regulate commercial aspects of the professions.

The Ninth Circuit cited imperfections in the competitive nature of the health care industry as a basis for its reluctance to ban price fixing practices on ***per se*** grounds. In effect, the majority opinions would allow private parties to engage in regulation of the health care industry, subject to the rule of reason. Regulation should be the sole province of the legislatures. ***United States v. Topco Associates, Inc.,*** 405 U.S. 596, 611 (1972).

Although the Ninth Circuit's departure from established precedent is a matter of utmost concern, the most serious problems presented by the majority opinions involve the practical application of those opinions. Some of the more serious questions are:

1. If the legality of price fixing is subject to rule of reason analysis in health care antitrust cases, does rule of reason analysis also apply to all other types of antitrust violations which have traditionally been illegal ***per se*** in every other industry.

2. Will the "reasonableness" of price fixing in the health care industry vary from region-to-region, and from jury-to-jury, depending on the current philosophy of each jury.

3. Will summary judgment be inappropriate in all

health care cases, regardless of the severity of the violation, because a question of fact is always presented with respect to the reasonableness of the conduct.

4. Will criminal prosecution for price fixing in the health care industry be possible, in view of the difficulty in establishing illegal intent, beyond a reasonable doubt, when the rule of reason is the test for determining illegality.

Another serious practical problem which results from the Ninth Circuit's majority opinions involves the time and expense devoted to correcting what has traditionally been the easiest type of antitrust violation to remedy. If summary judgment is not in fact precluded in the health care industry by the Court of Appeals' opinions, summary judgment in traditional *per se* type cases would no doubt be extremely difficult. In almost every situation a full trial will be required. Private enforcement will no doubt be discouraged. The larger health-care-related organizations will be inclined to "roll the dice" on the outcome of any particular jury's appreciation of the "reasonableness" of the conduct involved. Often the stakes will be enormous in both social and economic impact. Consequently, the attention of the judicial system will be burdened even further with the explosion of health-care related litigation already reaching significant proportions.

As this Court stated in *Northern Pacific Railway v. United States*, 356 U.S. 1, 5 (1958):

> "[T]here are certain agreements or practices which because of their pernicious effect on competition and lack of any redeeming virtue are conclusively presumed to be unreasonable and therefore illegal without elaborate inquiry as to the precise harm they have caused or the business excuse for their use. This principle of

per se unreasonableness not only makes the type of restraints which are proscribed by the Sherman Act more certain to the benefit or everyone concerned, but it also avoids the necessity for an incredibly complicated and prolonged economic investigation into the entire history of the industry involved, as well as related industries, in an effort to determine at large whether a particular restraint has been unreasonable - - an inquiry so often wholly fruitless when undertaken. Among the practices which the courts have heretofore deemed to be unlawful in and of themselves are price fixing . . . ; division of markets . . . ; group boycotts . . . ; and tying arrangements . . . . " (citations omitted.)

CONCLUSION

The decision of the Ninth Circuit is contrary to established antitrust law. There is no basis for the application of rule of reason analysis in *per se* situations to all professional relationships in the health care industry, and the decision could pose an insurmontable obstacle to private and public enforcement in the health care industry.

It is respectfully submitted that this Court should reverse the Ninth Circuit, and hold that:

1. The *per se* test for determining the illegality of price fixing under the antitrust laws also applies to the health care industry; or

2. Alternatively, should the Court conclude that the health care industry warrants special analysis in determining the legality of price fixing, such a rule should only apply to matters directly related to the professional relationship, and the established tests for determining legality would apply to the commercial aspects of the health care industry.

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This is to certify that on the 4th day of June, 1981, the original and thirty-nine copies of the Brief for Chalmette General Hospital, Inc., Thian & Company, Montelepre Memorial Hospital, and St. Charles General Hospital as Amicus Curiae were forwarded by air courier from New Orleans, Louisiana, addressed to:

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ON WRIT OF CERTIORARI
TO THE UNITED STATES COURT OF APPEALS
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BRIEF OF HOSPITAL BUILDING COMPANY AS AMICUS CURIAE IN SUPPORT OF PETITIONER, THE STATE OF ARIZONA

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BRIEF OF HOSPITAL BUILDING COMPANY AS AMICUS CURIAE IN SUPPORT OF PETITIONER, THE STATE OF ARIZONA

On consent of all of the parties, Hospital Building Company submits this brief amicus curiae in support of the petitioner, the State of Arizona.

INTEREST OF THE AMICUS CURIAE

Hospital Building Company ("HBC") is plaintiff-appellee in an antitrust suit in the United States District Court for the Eastern District of North Carolina entitled *Hospital Building Co. v. Trustees of the Rex*

Hospital ("*HBC v. Rex*"), Civil Action No. 4048.[1] HBC is a subsidiary of a proprietary hospital building and management company. Thus, HBC, and its parent company, are vitally concerned that the market for health care services is free and open and that competition in the health care industry is not subjected to artificial and anticompetitive restraints imposed by private parties acting in their own interests and without express congressional direction and approval.

During the trial of *HBC v. Rex* one question presented to the District Court was whether a conspiracy: (i) to exclude HBC from competing for the business of providing hospital services in the Raleigh, North Carolina market; (ii) to prevent HBC from expanding its hospital to share in the growth of the market for hospital services; and (iii) to allocate customers and types of hospital services among the two other existing hospitals in the Raleigh market, if proven, should be considered a *per se* violation of Section 1 of the Sherman Act, 15 U.S.C. § 1,[2] or considered under the Rule of Reason. The defendants contended that the District Court should permit them to introduce evidence as to

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[1] The case was previously before this Court to determine whether the federal courts had jurisdiction under the Sherman Act over the claims set forth in HBC's complaint, specifically, whether sufficient effects on interstate commerce were alleged. This Court held that the Sherman Act covered the offenses alleged. *Hospital Building Co. v. Trustees of Rex Hospital*, 425 U.S. 738 (1976).

[2] HBC also brought its action to recover treble the amount of damages incurred by HBC as a result of violations by one defendant of Section 2 of the Sherman Act, 15 U.S.C. §2, and the jury found in favor of HBC on this claim as well as on the Section 1 claim.

the unique aspects of the health care industry in general, for the purpose of excusing the anticompetitive impact of their conspiracy with others which resulted in the blocking of HBC's efforts to relocate and expand its hospital facilities in Raleigh, and the allocation among the defendants and their co-conspirators of the provision of hospital services in the Raleigh, North Carolina area. The District Court rejected the defendants' contention, however, and ruled that an exclusionary horizontal conspiracy among competing health care providers must be treated under a *per se* antitrust standard. The District Court therefore: (i) excluded opinion evidence concerning the nature of the "health care" industry in general, and (ii) charged the jury on a *per se* standard as to HBC's Section 1 claims.

State of Arizona v. Maricopa County Medical Society, No. 80-419, raises the general issue common to both this case and *HBC v. Rex*[3] of whether restraints, traditionally given *per se* treatment because of their inherently severe and pernicious impact upon competition, should be analyzed under the *per se* rule or the Rule of Reason when activity in the health care industry is being challenged. Thus, the arguments to be presented before this Court and the decision of this Court could be material and germain to an important issue which will undoubtedly arise in the appeal of

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[3] There is a material difference between HBC's suit and the instant case. In this case the Court is faced with a relatively direct link to the fee-fixing practices of the medical care profession. The restraint imposed upon hospital building construction and related services in *HBC v. Rex*, on the other hand, involved only incidentally the practice of medicine.

HBC v. Rex. HBC fully supports the contention of the petitioner here that restraints consistently treated as *per se* violations have the same character in the health care industry and that, therefore, the *per se* standard should be applied in the health care industry just as in any other industry, absent congressional action to limit or abolish the application of that standard. HBC also, however, has a separate fundamental interest to insure that, whatever the decision in this case on the agreement among the competing members of the medical profession to establish fee schedules and thus regulate competition, this Court does not establish a precedent which would eliminate competition in the health care industry by allowing the absolute exclusion of competitors from markets.

SUMMARY OF ARGUMENT

The particular type of restraint involved in the instant case is price-fixing. This Court has never condoned price-fixing because the prices fixed were reasonable, because the price-fixing agreement was entered into by a professional or because the price-fixing occurred in a particular industry with supposedly unique characteristics. This Court, therefore, should treat the price-fixing agreement in the present case just as it has traditionally treated price-fixing agreements, using the *per se* standard of antitrust scrutiny.

Congress, the body to which all requests for antitrust exemptions should properly be addressed, has never exempted all activities in the health care

industry from the Sherman Act.[4] In some limited instances, specific exemptions have been granted, but no such exemption exists for the price-fixing agreement in the instant case. For this reason, the Ninth Circuit's argument that the characteristics of the marketplace for health care services could possibly make monopolistic and other anticompetitive arrangements preferable to competition as a means of controlling prices is foreclosed.

Contrary to the Ninth Circuit's suggestion in the case at bar, there is no inherent contradiction between the *per se* rule and the Rule of Reason such that the *per se* rule cannot be appropriately applied in the instant case. Rather, the *per se* rule is a category of Rule of Reason analysis, reflecting that courts have concluded that anticompetitive impact exists in a certain case because experience has taught that a particular practice is inherently anticompetitive. When the Rule of Reason is understood in this way, it is clear that the proper focus of the Ninth Circuit in the instant case should have been on the particular type of restraint involved rather than on the suggested complex characteristics of the health care industry.

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[4] Indeed, *National Gerimedical Hospital and Gerontology Center v. Blue Cross of Kansas City*, 479 F.Supp. 1012 (W.D. Mo. 1979), *aff'd* 628 F.2d 1050 (8th Cir. 1980), *cert. granted*, 49 U.S.L.W. 3531 (January 26, 1981) (No. 80-802), presently pending before this Court, involves the question of whether congressional authorizations for particular activities in the health care industry constitute an implied repeal of the Sherman Act as to those activities and as to the persons who participate in them.

ARGUMENT

I. The Anticompetitive Impact of Respondents' Conduct and of the Restraints of Trade Involved May Properly be Presumed.

A. *IN RULING THAT THE REASONABLENESS OF AN AGREED UPON PRICE IS A DEFENSE TO A PRICE-FIXING CHARGE, THE NINTH CIRCUIT HAS DEPARTED FROM A CONSISTENT AND UNBROKEN LINE OF DECISIONS BY THIS COURT.*

This Court has long held that an agreement which interferes with the setting of price by free market forces is illegal on its face. *United States v. Socony-Vacuum Oil Co.*, 310 U.S. 150 (1940); *United States v. Trenton Potteries Co.*, 273 U.S. 392 (1927); *United States v. Addyston Pipe & Steel Co.*, 175 U.S. 211 (1899). This fact was most recently reaffirmed in *Catalano, Inc. v. Target Sales, Inc.*, 446 U.S. 643 (1980). There, this Court, in a *per curiam* opinion, held that:

> A horizontal agreement to fix prices is the archetypal example of such a practice. It has long been settled that an agreement to fix prices is unlawful *per se*. It is no excuse that the prices fixed are themselves reasonable.

Id. at 647. Furthermore, this Court's opinion in *National Society of Professional Engineers v. United States*, 435 U.S. 679, 692-693 (1978), directed that Rule of Reason analysis *should not* be used when a

trade restriction results in the fixing of rates or prices by private agreement, notwithstanding allegations in that case that professional engineers have a unique place in society and that the professional engineer is responsible for public projects and other activities which arguably are vested with a peculiar public interest. This Court in *Professional Engineers* wrote:

> The Rule of Reason suggested by *Mitchel v. Reynolds* has been regarded as a standard for testing the enforceability of covenants in restraint of trade which are ancillary to a legitimate transaction, such as an employment contract or the sale of a going business. Judge (later Mr. Chief Justice) Taft so interpreted the Rule in his classic rejection of the argument that competitors may lawfully agree to sell their goods at the same price as long as the agreed-upon price is reasonable. *United States v. Addyston Pipe & Steel Co.* 85 F. 271, 282-283 (CA6 1898), *aff'd*, 175 U.S. 211, 44 L.Ed. 136, 20 S.Ct. 96. That case, and subsequent decisions by this Court, unequivocally foreclose an interpretation of the Rule as permitting an inquiry into the reasonableness of the prices set by private agreement. (footnote omitted).

Professional Engineers, supra at 689.

The foregoing cases make clear that an attempt to invoke the unique status of an industry to change a *per se* case into a Rule of Reason case fails where the restraint is price-fixing.

B. *THE SUPPOSEDLY UNIQUE CHARACTERISTICS OF THE HEALTH CARE INDUSTRY ARE IRRELEVANT WHERE THE RESTRAINT INVOLVED IS A PER SE VIOLATION.*

1. *There is No Special Standard for the Analysis of Anticompetitive Restraints Involving Professional Medical Services.*

Medical professionals who engage in price-fixing may not invoke their occupations as a shield against attack under the Sherman Act. The scope of an antitrust exception for professionals was sharply curtailed in *Goldfarb v. Virginia State Bar*, 421 U.S. 773 (1975), where this Court struck down a minimum fee schedule for real estate title examinations imposed by a county bar association. Additionally, in *Professional Engineers, supra*, where the canon of ethics of the petitioner's professional society prohibited its members from submitting competitive bids for engineering services, this Court rejected another opportunity to create a professional services immunity doctrine. *Goldfarb* and *Professional Engineers* reaffirm what the Sherman Act directs: Where price-fixing is an issue, judicial focus, even when professionals are involved, should be on the particular anticompetitive practice at issue as opposed to the occupation of the offenders of the antitrust laws.

2. *To Rule That Anticompetitive Restraints Already Defined as Per Se Unlawful May be Acceptable in the Health Care Industry Would Exempt that Industry from Established Standards of Antitrust Enforcement.*

The Ninth Circuit somehow concludes that because of the special nature of the health care industry, anticompetitive arrangements could better promote trade. As a result, the Ninth Circuit determined that the health care industry is exempt from established antitrust analysis. It should be noted, however, that Congress, the body to which all requests for antitrust exemptions should properly be addressed, has made it clear that it values competition in the health care industry.[5] In addition, Congress, even though it has ex-

[5] In fact, in the 1979 amendments to the 1974 National Health Planning and Resources Development Act, 42 U.S.C. §300K *et seq.* (1976 ed.), where Congress provided only limited exemptions from the antitrust laws for health systems agencies and their officials or employees acting within the scope of the duties specifically outlined for them under the Act, Congress expressed its intent that competition should prevail in the health care industry. Presently mandated as a national health priority is:

> (17) The strengthening of competitive forces in the health services industry whenever competition and consumer choice constructively serve . . . to advance the purpose of quality assurance, cost effectiveness, and access.

National Health Planning and Resources Development Amendments of 1979, 42 U.S.C. §300K-2(a)(17) (1979 Supp. III). To the same effect is another congressional provision:

> (3) For the health services for which competition appropriately allocates supply consistent with health systems

empted other industries from the antitrust laws,[6] has never seen fit to insulate the health care industry in its entirety from competition.

In view of the foregoing, the Ninth Circuit's opinion that the anticompetitive characteristics of the medical marketplace could make monopolistic arrangements preferable, sharply diverts from the will of Congress.

C. *THERE IS NO CONTRADICTION BETWEEN THE PER SE RULE AND THE RULE OF REASON SUCH THAT THE PER SE RULE CANNOT BE APPROPRIATELY APPLIED IN THE CASE AT BAR.*

The Ninth Circuit's opinion suggests that there is an intrinsic contradiction between the *per se* rule and the Rule of Reason. In point of fact, however, no such contradiction exists. Every successful Sherman Act case must include a showing of an "unreasonable" restraint on competition. The *per se* rule is a category of analysis under the Rule of Reason which has as its

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plans and State health plans, health systems agencies and State health planning and development agencies should in the performance of their functions under this subchapter give priority . . . to actions which would strengthen the effect of competition on the supply of such services.

42 U.S.C. §300K-2(b)(3) (1979 Supp. III).

[6] Congress has exempted certain industries from the reach of the Sherman Act. *See, e.g.*, 7 U.S.C., §§291-292 (1976 ed.) (Capper-Volstead act, agricultural cooperatives); 15 U.S.C. §§1011-1013 (1976 ed.) (McCarran-Ferguson Act, insurance); 15 U.S.C. §1801 (1976 ed.) (Newspaper Preservation Act, newspaper joint operating agreements).

purpose determining whether the restraint is of a type which historically has been determined to be so hostile to competition that no further examination of its effects need be made. *Northern Pacific Ry. Co. v. United States*, 356 U.S. 1,5 (1958).

Ultimately, then,

> . . . [T]he *per se* doctrine is precisely a special case of rule of reason analysis. Where experience teaches that a particular practice is of a kind which blatantly restricts competition, we then know without further analysis how the balance will come out; we are spared the need for elaboration. Price fixing, for example, is a naked restraint of competition. Even if in some particular manifestation its negative impacts may be muted, it is hard to conceive that there would be any consequent enhancement of competition in some other respect or, if there were, that the enhancement would be so great as to render the restraint insignificant.

L. SULLIVAN, HANDBOOK OF THE LAW OF ANTITRUST § 72 (1977).

Combined with the Ninth Circuit's misconception of *per se* analysis is a misunderstanding of the purpose of the Rule of Reason. As this Court stated in *Professional Engineers, supra* at 688:

> Contrary to its name, the Rule [of Reason] does not open the field of antitrust inquiry to any argument in favor of a challenged restraint that may fall within the realm of reason. Instead, it focuses directly on

the challenged restraint's impact on competitive conditions.

Thus, the Ninth Circuit's shift of focus from the nature of the restraint to the industry involved misapplies both the *per se* doctrine and the Rule of Reason. Whenever a federal court is reviewing a challenged restraint of trade pursuant to the Rule of Reason, the court need not study the intricacies of a given trade practice, the characteristics of the industry in which the practice takes place, the public interest, or the interest of the members of the industry, any further than is necessary to make a fully informed determination of the restraint's impact on competitive conditions in the relevant marketplace. *Professional Engineers*, *supra* at 692. When, however, a federal court is reviewing a challenged restraint of competition pursuant to the *per se* rule, the restraint's impact on competitive conditions in the marketplace is presumed. No further inquiry into the restraint's purpose or economic impact is necessary to show a violation of the Sherman Act. *Id.*

II. Conclusion

For the foregoing reasons, the amicus, Hospital Building Company, respectfully requests that this Court reverse the Ninth Circuit's opinion in the case at bar and hold that health care professionals and the health care industry possess no special characteristics which change the long-recognized rule that a horizontal collaboration among competing health care providers to fix prices should be treated by courts under a *per se* antitrust standard.

Respectfully submitted this 23rd day of May, 1981.

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Case No. 80-419

IN THE

SUPREME COURT OF THE UNITED STATES

OCTOBER TERM 1980

Office-Supreme Court, U.S.
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ALEXANDER L. STEVAS,
CLERK

STATE OF ARIZONA

Petitioner,

vs.

MARICOPA COUNTY MEDICAL SOCIETY,
Maricopa Foundation for Medical Care, and
Pima Foundation for Medical Care.

Respondents.

ON CERTIORARI TO THE UNITED STATES COURT OF APPEALS, FOR THE NINTH CIRCUIT

BRIEF FOR THE STATE OF OHIO *AMICUS CURIAE* SUPPORTING THE STATE OF ARIZONA

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BRIEF FOR THE STATE OF OHIO *AMICUS CURIAE* SUPPORTING THE STATE OF ARIZONA

INTEREST OF AMICUS CURIAE STATE OF OHIO

Private market economics and the antitrust laws are to the medical profession what Copernicus' ideas were to the western world of the 16th Century: a fundamentally new way of thinking about reality.

For decades medical societies have viewed themselves as the proper centers of health care's economic universe. Over these many years a guild mentality has become firmly embedded in medical societies and the medical profession.

Market principles, of course, are entirely different from the guild concepts that have dominated medical society thinking for so long. The center of its economic world is the market, not the medical society.

For six years the Attorney General of Ohio has had first hand exposure to the guild thinking and conduct of the health professions.[1] He is convinced that as long as that guild mentality persists, antitrust violations will proliferate. In addition, private sector efforts by the medical profession and others to control soaring health care costs will be undermined. Neither result is in the best interests of Ohio consumers or health professionals.

The instant case is of great importance to the State of Ohio because it presents a classic application of the medical guild model to private markets. An incisive opinion by this Court against the Respondents can remove these guild precepts, and replace them with private market principles. Such an opinion would greatly facilitate antitrust enforcement in the courts. It would also materially advance the most effective antitrust "enforcement" of all: a properly functioning, self-correcting, private market for health care.

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1. *Ohio v. Ohio State Medical Assn.*, 5 CCH Trade Regulation Rep. Para 50,396 (May 7, 1979) (S.D. Ohio) (July, 1975 suit settled in March, 1979; Medical Society forced to give up its complete control of Ohio Medical Indemnity - Blue Shield - which pays physicians $300 million a year. The company is now owned by its policyholders, has a majority of new board members, and can have no more than 4 physicians on its 21 member board); *Ohio v. Mahoning County Medical Society*, 1978-2 CCH Trade Cases Para 62,226 (N.D. Ohio) (August, 1976 complaint accuses Youngstown, Ohio hospitals and physicians of boycotting an HMO out of business); *Ohio v. Greater Cleveland Hospital Assn.*, No. C-80-1305 (N.D. Ohio) (July, 1980 complaint accuses a local hospital association of conspiring with its members to grant preferential prices to Blue Cross, collectively refusing and reducing competitive discounts, and agreeing not to compete in the insurance market); *Ohio v. Joint Commission for the Accreditation of Hospitals*, No. C-2-79-1158 (S.D. Ohio) (December, 1979 complaint charges JCAH with conspiring with the AMA and other physician organizations to eliminate competition from psychologists in hospitals); *Ohio v. Ohio Dental Assn.*, No. C-2-79-1058 (S.D. Ohio) (November, 1979 settlement ordered the divestiture of dentist control of Delta Dental Plan of Ohio and the elimination of ethics against contract practice); *Ohio v. Ohio Optometric Assn.*, No. C-2-80-388 (S.D. Ohio) (May, 1980 complaint against Ohio Optometric Association and Ohio Vision Services seeks divestiture of optometrist control of Ohio's largest vision benefit insurer and an end to anticompetitive restrictions on optometrist members); and *Ohio ex rel Brown v. Alliance Dental Society*, 1976-1 CCH Trade Cases, Para 60,944 (Ohio C.P.) (consent judgment against dentist boycott of state Medicaid Program).

SUMMARY OF ARGUMENT

A close examination of the Respondent medical society and foundations' fee agreements among 70% of area physicians reveals classic medical guild conduct wholly lacking in any redeeming values. Masked behind the high sounding labels "foundation," "cost containment," and "competitive alternative", is a simple collective bargaining agent with overwhelming market power negotiating physician fees with insurers. There is no partial integration by the physician members of the foundations incidental to the joint price-fixing, nor are there special features of the medical services market requiring such an enormous aggreagation of market power by the Respondents.

There are, moreover, far more competitive methods of providing "paid-in-full" insurance benefits than the foundation fee agreements, such as participating contracts. The Respondents' fee agreements eliminate these competitive alternatives, and thus foreclose competition in both the physician and insurance markets.

In the final analysis, the foundation fee agreements' purpose and effect is to perpetuate a guild model of health care delivery devoid of price competition among physicians. The unfortunate side effect for physicians and the public is the perpetuation of a system basically lacking self-correcting private incentives for efficiency and effectiveness. Accordingly, the Respondents price-fixing activities violate Section One of the Sherman Act under either a *per se* or truncated rule of reason analysis.

ARGUMENT

I. RELEVANT BACKGROUND ON THE HEALTH CARE INDUSTRY, THE GUILD MODEL AND THE COMPETITIVE ALTERNATIVES.

A. The Persistent Probelm of Soaring Health Care Costs.

That health care costs continue to soar, straining both public and private finances, is undisputed. Between 1970 and 1980, the nation's health care bill more than tripled to nearly

$250 billion, and in the next ten years is expected to triple again. Freeland, Calat & Schendler, *Projections of National Health Expenditures, 1980, 1985 and 1990,* 2:3 HEALTH CARE FINANCING REV. 1, 2 (1980). In Ohio, state and local government expenditures for health rose 315% in ten years to $1.3 billion in 1979, while overall governmental expenditures increased only 173% during the same period. *Ohio Governments' Spending climbs 173% in Past Decade,* Cleveland Plain Dealer, Nov. 20, 1980 at 10-B. The City of Cleveland was just informed of a 45% increase in the cost of Blue Cross hospital insurance for its employees. Clark, *Hospitalization Rates to Leap for City Workers,* Cleveland Plain Dealer, May 8, 1981 at 13-A.

Private sector health care costs have also been skyrocketing. Between 1965 and 1980, private spending climbed from $32 billion to $144 billion. Freeland, et al., *supra,* at 2.

Health care costs have been rising at least 50% faster than inflation generally for many years. *Id.,* at 2-4. Recent indications are that health care costs are about to rise even more sharply. According to a Blue Cross-Blue Shield actuary, "[t]he easy part is over. The tough sledding is ahead." Waldholz, *Medical-Benefit Costs are Rising Sharply; Firms Tighten Controls, Redesign Plans,* Wall Street Journal, Sept. 25, 1980 at 48.

B. The Underlying Cause: The Perverse Incentives, or the Absence of Price Competition Among Providers.

The underlying cause of the excessive escalation of costs is well known - perverse incentives. The existing incentives facing patients, doctors, and hospitals are cost-generating, not cost-saving. It is generally recognized that "[p]robably the principal factor contributing to inflation has been the predominant system of third party reimbursement based on what institutions spend and what physicians charge."[2]

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2. HEW, *Forward Plan for Health: Fiscal Years 1980-1982* at 34 (1976). *See also* McClure, *The Medical Care System Under National Health Insurance; Four Models,* 1 J. HEALTH, POLITICS, POLICY & LAW 22, 33 (1976); Sen. Rep. on PL 93-141, No. 93-1285, 93d Cong., 2d Sess., *1974 U.S. Code & Admin. News* 7842, 7878.

Under the predominant forms of public and private health insurance, there is virtually no price competition between providers of health care services that give private incentives to doctors and hospitals to be efficient. In the system of "usual and customary fees" for physicians and cost reimbursement for hospitals that dominates health-care financing today, the question of the efficient use of resources does not even arise. Providers are not required to set priorities, look at alternatives and make hard choices. From the point of view of the provider, there is an apparently unlimited amount of money. This system rewards cost-increasing behavior with more revenue and punishes cost-reducing behavior with less revenue. Such a system must produce inflation in prices and waste in the use of resources.

To illustrate, it makes no difference to most patients whether they use the most extravagant doctor and hospital or the most efficient. For the vast majority of patients, insurance pays irrespective of choice. Reaping no reward, the rational consumer will forego the difficult effort of seeking out equally effective but less costly alternatives.

Under existing methods of reimbursement, the efficient physician is actually punished. The physician who avoids services of low or questionable efficacy, who substitutes less elaborate procedures for more costly procedures when equally effective, who treats in his office instead of the hospital whenever appropriate, loses income.

The general practitioner may refer a patient to a neurologist or a surgeon, order laboratory tests and x-rays and have the patient hospitalized. Physicians order services that directly or indirectly account for approximately 70% of all health care costs. Egdahl, *Fee For Service Health Maintenance Organizations,* 241 J.A.M.A. 588 (Feb. 9, 1979). Even though a physician's orders generate these costs, he or she has no "financial responsibility" for them. Thus, the physician has no incentive to seek out equally effective but less costly alternatives. "[M]ost physicians don't have the vaguest notion of what things they order cost." Am. Medical News, June 22, 1979 at 9 (quoting Dr. Darrell Cannon).

The same disincentives for efficiency and incentives for waste operate on hospitals. The hospital that closes excess capacity, avoids duplicative technology already located in nearby hospitals, screens out unnecessary admissions, and discharges patients as soon as medically appropriate, loses revenue.

Perverse incentives mean that doctors and other providers who do not restrain themselves are rewarded at the expense of those who do. Since extravagant medical care and conservative medical care are often equally medically effective but extravagant medical care is rewarded, a "spare no expense" mentality develops regardless of benefit that drives health care costs exorbitantly high – without any improvement in health outcomes.[3] Unless this system of perverse incentives that punishes cost-conscious behavior while rewarding inefficiency is changed, the health care industry will continue to experience unacceptably high inflation.

There are basically two approaches to solving the problem of perverse incentives - government regulation or private market incentives. Of course, the two approaches can be used in combination. *See generally* P. AREEDA & D. TURNER, 1 ANTITRUST LAW 133-78 (1978) (competition in regulated industries). The first, government regulation, attempts to use public economic controls as the substitute for missing market forces. One example of that approach is health planning, which is presently before the Court in *National Gerimedical Hospital v. Blue Cross of Kansas City*, No. 80-802 (argued 4-29-81).

3. V. FUCHS, WHO SHALL LIVE? (1974) & Enthoven, *Cutting Cost Without Cutting The Quality of Care*, 298 NEW ENGLAND J. MEDICINE 1229, 1234-35 (June 1, 1978) (curtailing "flat of the curve" medicine).

C. The Competitive Alternative: Provider Price Competition Over Fees and Premiums.

The second private market approach seeks to establish effective market forces for doctors and other providers in the health services market. Recently there has been a tremendous increase in both the interest in and number of proposals for using "competition" as a therapy for the health care field's feverishly high rates of inflation.[4]

The distinctive feature of the market apprach is not that it calls for competition between doctors and other health care providers, for there is already vigorous *non-price* competition at that level. *See, e.g.*, Williams, *How to Meet the New Demands in Ambulatory Care*, TRUSTEE, Dec., 1980 at 47. The distinctive feature is that it requires what the market requires: *price* competition at the provider level. In the words of Dr. Paul Ellwood, the person singularly most responsible for the development of the market approach, provider price competition is essential:

> There is one awesome condition that hospitals and physicians must meet if the market is to work fully: aggregations of doctors and hospitals have to compete with each other for comsumers on the basis of price. Price competition is a concept that is absent in health care throughout the world, but it is a necessity if price and expenditure controls are to be avoided.

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4. *See, e.g., Competition in Health Care: Would it Bring Costs Down?* CONG. Q. 1587 (August 4, 1979) for a discussion of the legislative proposals. The competitive policy analyses that follow are summarized in Enthoven, *Health Care Costs: Why Regulation Fails, Why Competition Works, How to Get There From Here*, NAT'L. J. 885 (May 26, 1979): McClure, *The Medical Care System Under National Health Insurance: Four Models*, 1 J. HEALTH, POLITICS, POLICY & LAW 22 (1976); A. ENTHOVEN, HEALTH PLAN (1980); Enthoven, *Cutting Cost Without Cutting The Quality of Care*, 298 NEW ENGLAND J. MEDICINE 1229 (June 1, 1978); W. McClure, *Comprehensive Market and Regulatory Strategies for Medical Care* (Inter Study 1980). *See also* Havighurst, *Health Maintenance Organizations and the Market for Health Services*, 35 LAW & CONTEMPORARY PROBLEMS 716 (1970). For the effects of provider competition in health care, *see* Christianson & McClure, *Competition in the Delivery of Medical Care*, 301 NEW ENGLAND J. MEDICINE 812 (Oct. 11, 1979); *In re American Medical Association*, 94 F.T.C. 701, 1013, 1016-18, (1978).

Ellwood, *The Importance of the Market,* 2 J. HEALTH, POLITICS, POLICY & LAW 447, 448 (1978).

As this Court stated long ago, price is the "central nervous system of the economy." *United States v. Socony-Vacuum Oil Co.,* 310 U.S. 150, 226 n. 59 (1940). Thus, price competition among health care providers is central to a market solution for the health care cost problem. Price competition among health care providers is a concept that never received serious study and analysis until recently, except by medical societies. Recent policy analyses have identified two profoundly different ways in which providers can engage in price competition: first, over fees, and second, over premiums.

Price competition over fees seeks to introduce provider price competition when the consumer needs health care services by changing existing health insurance coverage to require the patient to pay a portion of his or her medical bill. If the consumer has to pay a portion of the bill, an incentive to select a doctor or hospital on the basis of price along with other factors emerges. An example of this approach are the proposals for catastrophic health insurance. *See, e.g.,* Feldstein, *A New Approach to National Health Insurance,* 23 PUBLIC INTEREST 93 (1971); McClure, *The Medical Care System Under National Health Insurance: Four Models,* 1 J. HEALTH, POLITICS, POLICY & LAW 22, 44-47 (1980).

The second method of introducing provider price competition and incentives for efficiency is to generate *provider competition over premiums.* It starts from the premise that consumers may prefer comprehensive health insurance coverage. If all provider fees are covered, then there obviously can be no provider competition for patients over fees. The only price mechanism available under comprehensive coverage is the premium itself.

However, present competition over premiums is between insurers, not health care providers. Provider price competition over premiums requires distinct groups of providers who offer their services for a premium. Thus, in order

> to establish market forces and incentives under insurance, providers must be split into competing groups.

Ellwood & McClure, *Health Delivery Reform* at 2 (unpublished Inter-Study paper, Nov. 17, 1976).

Each group of doctors and hospitals offering their services for a premium are called "health plans" in the literature on competitive policy for medical services. Health plans would compete with traditional forms of insurance, and would create choice and price competition among groupings of providers over premiums. Obviously, an efficient group of providers could have a lower premium than an inefficient group. In such systems, physicians would accept responsibility for providing comprehensive health-care services to defined populations, largely for a prospective per capita payment, or some other form of payment that rewards economy in the use of health-care resources. Physicians control the lión's share of health-care expenditures, and are by far the best qualified to make the difficult judgments about need and cost effectiveness. It makes sense for physicians to accept the main responsibility for keeping health-care costs within the limits desired by society.

The classic example of a health plan is the closed panel health maintenance organization. It is only one of many forms that "health plans" can take, however. Other examples include Health Care Alliances and Individual Practice Associations, so long as the number of physicians involved do not have undue market power. Solo fee-for-service physicians who practice high quality medicine in a conservative and efficient manner which, under the present system is irrelevant to consumers, could ban together and organize a health plan. If they are efficient, then the premium for their health plan will be lower and people who chose it will receive more benefits for lower costs. On the other hand, it they pick providers who provide cheap and shoddy care, consumers would soon find out and switch to another plan. Or, if they choose providers who are good but expensive, the plan's premium would rise and consumers would look at their alternatives and pick a more cost-effective plan.

Thus, the market approach seeks to cure the single greatest cause of runaway health care inflation, perverse incentives, by altering the incentives facing doctors, hospitals and consumers. By altering incentives so that efficiency is encouraged, the private system will squeeze out its own excesses in a decentralized and diversified private market for health care services.

D. Medical Guild Opposition to Price Competition Among Providers.

Altering these perverse incentives requires introducing price competition among health care providers either over premiums or over fees. Provider price competition, however, is directly contrary to the medical guild mentality, and has been traditionally opposed by the profession. For more than 50 years, physician price competition has been considered unethical by the American Medical Association and its affiliated societies.

In a landmark ruling in 1978, the Federal Trade Commission documented at great length the use of medical society ethics to suppress price competition over fees and premiums. *In re American Medical Association.*[5] In addition to restraints on price advertising, the Commission struck down ethical restrictions that blocked physician price competition over premiums. Under the AMA's long established ethics, physicians were barred from entering into agreements with health plans or insurers that paid less than "usual fees", involved "underbidding", or were not open to any interested physician ("free choice"). 94 F.T.C. at 1012. According to the AMA, insurance arrangements that split physicians into groups competing over price were patently unethical:

5. 94 F.T.C. 701 (1978), *aff'd.* 1980-2 CCH Trade Cases Para 63,569 (D.C. Cir. 1980), *petition for cert. filed,* no. 81-1960 (1981). The administrative law judge's Nov. 13, 1978 opinion is 94 F.T.C. at 705, and the Commission's Oct. 12, 1979 affirming opinion 94 F.T.C. at 980.

> [I]t is evident from a facial examination of AMA's ethical provisions and from evidence concerning adoption of these restraints that they are *designed to limit price competition among doctors.*[6]

By rejecting price competition among physicians, the medical profession for over 50 years has fundamentally misperceived the nature of the free market system. Medical guild economics reverse private market principles. Contractual arrangements with health plans and insurers that create price competition among physicians are opposed as "unfair competi-

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6. *In re American Medical Association,* 94 F.T.C. at 1014. (Emphasis added.) Over the 50 year period the medical profession's ethics against physician price competition have been in effect and vigorously enforced, they have also been imposed on existing health insurance. *See, e.g.,* Note, *American Medical Association: Power, Purpose & Politics,* 63 YALE L.J. 937, 976-96 (1954); A. SOMERS & H. SOMERS, DOCTORS, PATIENTS, & HEALTH INSURANCE, 261-340 (1960); *American Medical Assn. v. United States,* 317 U.S. 519 (1943); *In re American Medical Association, supra,* 94 F.T.C. at 1013.

It would be a grevious error in public policy to consider the medical profession's adamant resistance to insurance arrangements that promote price competition among physicians a thing of the past. The AMA is seeking to have this Court overturn the FTC's landmark ruling, *In re American Medical Association, supra, petition for cert. filed,* no. 81-1960 (1981). The AMA's Executive Vice President recently stated that the AMA would be "violently opposed" to changes in public health insurance programs contrary to a key ethical provision struck down by the FTC as a restraint of trade. *See* Schorr, *Reagan's Medicaid Plan Stirs Fears of Two-Class Health Care System,* Wall Street Journal, Feb. 24, 1981, at 25, & *In re American Medical Association, supra,* 94 F.T.C. at 1015. Also, an AMA delegate recently described the Enthoven competitive health plan proposals to be "socialized medicine" because, in essence, they were inconsistent with these same illegal ethics against physician price competition over premiums. Rogers, *Pro-competition Bills and Socialized Medicine,* American Medical News, May 8, 1981 at 8. Deep-seated medical guild policies are not easily eradicated.

tion" and "unethical". Contractual arrangements that eliminate physician price competition are viewed as "fair competition" and "ethical".[7]

The AMA and its affiliated medical societies have a deeply rooted commitment to this guild model:

7. *In re American Medical Association, supra.* This fundamental misunderstanding of private market economics is reflected in a string of cases brought by doctors and other health professionals against participating contracts used by health plans and insurance companies. *E.g., Anderson v. Medical Service of the District of Columbia,* 551 F.2d 304 (4th Cir. 1977); *Kartell v. Blue Shield of Massachusetts, Inc.,* 592 F.2d 1191 (1st Cir. 1979); *Grigg v. Blue Cross & Blue Shield of Michigan, Inc.,* No. 772990 (E.D. Mich., filed Dec. 22, 1977) (physicians); & Enright, *Doctors v. Blue Shield: The First Big Battle,* MEDICAL ECONOMICS 23 (Nov. 27, 1978). *See also Group Life & Health Insurance Co. v. Royal Drug Co.,* 440 U.S. 205 (1979); *Sausalito Pharmacy, Inc. v. Blue Shield of California,* 1981-1 CCH Trade Cases Para 63,885 (N.D. Calif. 1981) (pharmacists); *Manasen v. California Dental Service,* 1981-1 CCH Trade Cases Para 63,959 (N.D. Calif. 1980) (dentist); *Doctors, Inc. v. Blue Cross of Greater Philadelphia,* 557 F.2d 1001 (3rd Cir. 1976) (hospitals).

The provider plaintiffs in these cases are alleging, in essence, that it is "anti-competitive" for an insurance company-buyer to make provider-sellers compete over price for the insurer's business and to refuse to deal with providers whose fees are too high. In the guild model, price competition is a restraint of trade.

> Because medicine tenaciously retained the personal relations which are essential to the treatment of disease, it clung to many features of the *guild form of organization* and the ethics based on these relations.[8]

Whenever consumer demand for a new service threatens to trigger price competition among physicians, the new service is simply recast into the medical guild mold.

Hence, the guild model of the medical marketplace is the key to a proper evaluation of the price setting practices of the Respondents medical society and foundations in this case. The medical profession's response to potential physician competition over fees or premiums in Arizona has been the guild organization in the form of medical foundations.

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8. AMA, ECONOMICS AND THE ETHICS OF MEDICINE 8 (1936) (Emphasis added). *See also* AMA, AN INTRODUCTION TO MEDICAL ECONOMICS 19 (1933) (Emphasis added):

> Recent national legislation proposes to extend the functions of such trade associations much further and to give them a very extensive control over the various industries and to hold them responsible for *the amount of production, for prices and for the competitive relations of their members. These are functions closely analogous to those long conducted by professional associations* and would seem to indicate that industry is finding it desirable to follow professional models rather than the reverse.

On the aggressive actions taken by medical societies to preserve the guild model, including boycott and collective bargaining, *see generally, In re American Medical Association, supra,* & Havighurst, *Antitrust Enforcement in the Medical Services Industry: What Does It All Mean?,* 58 MILBANK MEMORIAL FUND Q. 89 (1980).

II. THE MEDICAL SOCIETY FOUNDATIONS ARE ILLEGAL DOCTOR UNIONS COLLECTIVELY BARGAINING FEE AGREEMENTS FOR 70% OF AREA PHYSICIANS WITHOUT AN ANTITRUST EXEMPTION.

Careful examination of the undisputed facts in this case demonstrates that the Respondent medical society and foundations are mere fronts for classic guild conduct as to the challenged fee schedule agreements. The "foundations" are gauzy cloaks for the Respondents acting as "labor unions" collectively negotiating physician fees on behalf of 70% of area physicians with insurers - without benefit of labor's antitrust exemption. *American Medical Assn. v. United States,* 317 U.S. 519, 533-36 (1943) (medical society guild conduct on behalf of independent practitioners is not protected by the antitrust exemption for labor unions). *See generally* L. SULLIVAN, HANDBOOK OF THE LAW OF ANTITRUST 723-31, 719-22 (1977) (labor exemption and agricultural cooperatives exemption).

Under this Court's standards, the *per se* principle applies to "certain agreements or practices which because of their pernicious effect on competition and lack of any redeeming virtue are conclusively presumed to be unreasonable and therefore illegal without elaborate inquiry as to the precise harm they have caused or the business excuse for their use." *Northern Pacific R. Co. v. United States,* 356 U.S. 1, 5 (1958). Agreements completely eliminating price competition among 70% of the providers of physician services without any redeeming virtues summarily violate Section One of the Sherman Act (15 U.S.C. Section 1) under either a *per se* or truncated rule of reason analysis. *See also National Society of Professional Engineers v. United States,* 435 U.S. 679 (1978).

Respondents have asserted that a rule of reason analysis is appropriate because of the courts' unfamiliarity with the "medical foundation concept." A penetrating analysis of the undisputed facts in this case, however, demonstrates that the courts are, in fact, on familiar ground - the medical guild model. The foundation fee agreements' purpose and effect is to perpetuate a guild model of health delivery devoid of price competition among physicians.

It is undisputed that the Respondent medical society and foundations develop by agreement schedules of fees that are high enough to be acceptable to more than 70% of practicing physicians. Like a typical trade association or guild, the medical society foundation polls its physician members, consults with other medical associations and ultimately adopts an annual fee schedule only with the formal agreement of its physician members. (Pet. Brief for Cert. at 4).

It is further undisputed that the physician members have not integrated their practices in any way that requires joint price-fixing. The foundations are not insurers themselves. It is true that, in addition to setting agreed-to fees, the medical society foundations perform two other functions. First, foundations review the medical necessity and appropriateness of medical treatment and hospital utilization given to insured patients. Second, for some insured groups, the foundations also serve as agents for underwriters to facilitate claims payments to doctors. However, there is no suggestion, even by Respondents, that performance of either of these functions requires agreements on price. Clearly no such claim could be made, since the Maricopa Foundation provides these services to the State of Arizona's Comprehensive Medical Dental Program for Foster Children, and the state, not the Foundation, sets the physician fee levels. (Brief in Opp. to Cert. at 7).

In reality, then, the Respondent medical society foundations are simply illegal guilds or unions, which serve as the negotiating agent for "contracting physicians", and provide a "common front" in meeting "socioeconomic pressures." The Federal Trade Commission, in *In re American Medical Assn., supra,* made those precise findings as to similar medical society foundations in Connecticut:

> The [Connecticut State Medical Society] Council has urged the CSMS component medical societies to consider forming foundations for medical care on a county-by-county basis, each foundation to serve as the negotiating agent for contracting physicians in all matters having to do with third-party payments to physicians.

* * *

> Foundations "owned, controlled and administered by organized medicine" and incorporating fee-for-service medicine as a basic principle are one means available to medical societies to protect the interests of practicing physicians. They provide physicians with a "common front in meeting the socioeconomic pressures facing the practice of medicine," such as presented by HMOs, where fees are not necessarily controlled by doctors.

94 F.T.C. at 787-88. (Citations omitted).

The pernicious anticompetitive effects of the physician-controlled foundations here are manifest. As the collective bargaining agents for 1,000 physicians in Maricopa County and 400 physicians in Pima County, (Pet. Brief for Cert. at 3), the Respondent medical society foundations orchestrate a horizontal agreement on fees acceptable to fully 70% of all participating physicians. The foundations' fee agreements thus eliminate any actual or potential price competition among 70% of each area's physicians for the foundations' insurance company customers. This enormous market power is reminiscent of much earlier *per se* price-fixing cases. *See, e.g., Sugar Institute, Inc. v. United States,* 297 U.S. 553 (1936) (70-80%); *United States v. Frankfort Distilleries, Inc.,* 324 U.S. 293 (1945) (75%); *United States v. Line Material Co.,* 333 U.S. 287 (1948) (41%); and *United States v. Women's Sportswear Mfrs' Assn.,* 336 U.S. 460 (1949) (50%).

The Respondents and the Court of Appeals make much of the fact that the foundation fee agreements among physicians set "maximum" fees. Any agreement between a buyer and seller for the purchase of goods or services sets a "maximum" price. Certainly, every collective bargaining agreement sets a maximum price. The key issue is not whether a maximum or minimum price is set, but whether physician price competition is significantly restrained. A collective bargaining agreement on behalf of 70% of area physicians clearly restrains physician price competition to a significant extent.

Indeed, these medical society foundation fee agreements have more pernicious anticompetitive effects than the usual price-fixing agreement. Ordinary price-fixing agreements operate in industries where price-fixers have an incentive to break from the fold and obtain more business by undercutting the cartel price agreement. *See* R. POSNER, ANTITRUST 96-98 (1981). Here, there is no incentive for member physicians to break from the guild and charge lower fees because, under the foundations' fee agreements, the physician will not get any new business. And since patients with foundation-affiliated insurance have paid-in-full benefits, there is no incentive for the patient to seek out a physician that charges less than the foundation's fee schedule. Accordingly, there is no incentive for the physician to charge less than the foundation's fee schedule.

The fact that some doctors charge less than the medical society foundation fee schedules simply reflects the nature of the profession, not the glimmer of any physician price competition. This Court has long recognized that price-fixers can eliminate price competition without charging identical prices or rigidly following a fee schedule. *United States v. Socony-Vacuum Oil Co.*, 310 U.S. 150, 225 n. 59 (1940). *Accord Catalano, Inc. v. Target Sales, Inc.*, 446 U.S. 643 (1980); *Nationwide Trailer Rental System, Inc. v. United States*, 156 F. Supp. 800 (D. Kan.), *aff'd.* 335 U.S. 10 (1957). In *Plymouth Dealers Assn. v. United States*, 279 F.2d 128 (9th Cir. 1960), the Ninth Circuit concluded that it was illegal for competing new car dealers to agree upon a "list price", even though customers invariably bargained over the price and autos were rarely sold at that price. Here, Respondents have much greater market power than the Plymouth dealers. Even more significant is the fact that there is no incentive for patients to bargain over physicians' prices. Hence, the medical society foundations' fee agreements have far more anticompetitive effects than the price-fixing agreements held unlawful in *Plymouth Dealers, supra.*

No elaborate industry analysis is required to conclude that a schedule of fees collectively agreed to by over 70% of an area's practicing physicians is above competitive levels. Whether the medical society foundation fee schedules are higher or lower than what the same physicians charge in other non-competitive settings is not the critical comparison. The critical comparison is to fee levels that would be established by a more competitive

process than a guild. Collective fee agreements by over 70% of the providers of medical services are self-evidently higher than competitive levels and are inherently inflationary over time.

Perhaps the most pernicious effect of the foundations' horizontal fee agreements is that they perpetuate an insurance system devoid of price competition between physicians and inhibit private incentives for efficiency. By collecting together all the physicians interested in responding to a market for service benefits, the foundations stop cold a competitive chain reaction among physicians and insurers. Central to the medical guild mentality is the principle "united we stand, divided we fall". This principle makes any system of private market reform of the health care industry impossible. The private market will only work if some physicians are divided into groups competing on the basis of quality and efficiency. Ellwood, *supra.* The foundation fee agreements foreclose competition among insurers over alternative, more aggressive methods of minimizing the costs of medical services. *See Group Life & Health Insurance Co. v. Royal Drug Co.,* 440 U.S. 205 (1979). Aggressive cost containment by insurers could in turn provoke groups of physicians without undue market power to form their own health plans to compete with insurers and their fellow physicians.

The affidavit of the executive director of the Maricopa Foundation for Medical Care, Anthony Mitten, confirms these anticompetitive effects. Mr. Mitten states that his Foundation "was established to provide. . .a competitive alternative to utilization of closed panel prepaid health insurance plans." First, his statement shows the vitality of competition in the physicians market, since competitive alternatives prompted the formation of the Foundation. *See In re American Medical Assn., supra,* 94 F.T.C. at 1013. Second, the medical society's "competitive" response was anticompetitive – countering "closed panel" health insurance plans. "Closed panel" is the medical profession's code word for plans that generate price competition among physicians. *See, e.g.,* F.T.C. Bureau of Competition, *Medical Participation in Control of Blue Shield and Certain Other Open-Panel Prepayment Plans* 280-301 (April, 1979) (hereafter "FTC Report"); *In re American Medical Assn., supra.* Thus the medical society foundation fee agreements foreclose competition in both the physician services and insurance markets over innovative methods of financing health care.

Furthermore, there are no redeeming values to the foundations' fee agreements that cannot be achieved in far less anticompetitive ways, nor special characteristics of the physician services market that save them from *per se* or truncated rule of reason illegality.

It is undisputed that the foundations' fee agreements are separate and distinct from the other foundation services. The foundations' fee agreements, like the pharmacy agreements in *Group Life & Health Insurance Co. v. Royal Drug Co.*, 440 U.S. 205, 214 (1979), "are merely arrangements for the purchase of goods and services by" insurers. There are far more competitive ways for insurers to purchase physician services than through collective negotiations with medical society guilds representing 70% of the physician market. As the Court found in *Royal Drug, supra,* an insurer could use participating contracts, exclusive contracts, and even integrate into the physician services market.[9] There is nothing unique in the market for medical services, other than the unlawful ethical restrictions on physician price competition (documented in the 1978 FTC *American Medical Association* ruling), that makes it impracticable for insurers to establish maximum payment agreements with physicians.

Participating contracts with physicians or other health care providers have been used by some insurers for years. *See, e.g.,* F.T.C. Report, at B3-B9; *Royal Drug Co., supra.* Each insurer develops its own participating contract according to its own blend of goals, needs, bargaining position, market demand and abilities, and offers it unilaterally by mail to each physician. Collective negotiations with physicians are no more necessary than collective negotiations with policyholders over standard form contracts.

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9. *Id.* at 215. *See also* P. WILLIAMS, THE PURCHASE OF MEDICAL CARE THROUGH FIXED PERIODIC PAYMENT (1932); AMA, NEW FORMS OF MEDICAL PRACTICE (1933). These publications demonstrate that service benefits were the predominant form of what is now called health insurance before commercial insurers or Blue Cross-Blue Shield plans were in the market. The health profession's Blue Cross-Blue Shield plans were first established in the early 1930's, after these publications on service benefit plans were printed. *See* O. ANDERSON, BLUE CROSS SINCE 1929 at 31-35 (1975).

Consistent with the competitive diversity of private markets, the fee levels and conditions of participation may vary considerably between insurers. Some may choose to use incentives for physicians to sign their participating agreements, such as paying nothing for services rendered to non-participating physicians, or circulating lists of participating providers to patients. *E.g., Kartell v. Blue Shield of Massachusetts, Inc.*, 592 F.2d 1191 (1st Cir. 1979). Another incentive that is often used is to pay participating providers directly, rather than the patient, thus improving a doctor's cash flow and reducing bad debts. Non-participating doctors, on the other hand, must collect their fees from their patients, who are then indemnified by their insurers. *See, e.g., Anderson v. Medical Service of the District of Columbia,* 1976-1 CCH Trade Cases Para 60,884 (E.D. Va. 1976). Participating physician contracts have been used by different insurers for years, covering from 130 to nearly 20,000 physicians, and from 24% to 99% of practicing physicans. FTC Report at B3-B9. Participating contracts have long been used by commercial insurers as well as Blue Shield plans. *See, Hearings on Third Party Prepaid Prescription Programs before the Subcommittee on Environmental Problems Affecting Small Business of the H. Select Comm. on Small Business,* 92d Cong., 1st Sess., 227-70 (1971).

There is even a less restrictive alternative available to medical societies or their foundations. It would be perfectly lawful for a medical society or foundation to gather statistics on physician fees. G. LAMB & C. SHIELDS, TRADE ASSOCIATION LAW & PRACTICE 34-53 (1971). The medical society or foundation could provide that information for a fee to insurers to use unilaterally in setting physician reimbursement in their participating contracts.

In addition to participating contracts, insurers may enter into exclusive dealing agreements with a group of physicians or integrate into the physician services market and have physicians on salary. INA Health plan of Arizona in Phoenix, a group practice health maintenance organization recently acquired by INA, is illustrative. *See* Dept. Health & Human Services, 3 HMO Focus 1 (Dec., 1980) & 4 HMO Focus 1 (Feb., 1981) (INA also active in HMOs). *See generally* Tax Expenditures for Health Care, *Hearings before the Task Force on Tax Expendi-*

tures & Tax Policy of the H. Comm. on the Budget, 96th Cong., 1st Sess. at 235, 241-46 (1979). (Ellwood statement); A. Enthoven, *Consumer-centered v. Job-centered Health Insurance*, 57 HARVARD BUS. REV. 141 (Jan. 1979).

Commercial insurers have generally used participating contracts with non-physicians such as pharmacists. However, the primary reason *commercial* insurers have not used participating contracts and other competitive arrangements extensively with *physicians* is that such arrangements "violated" medical society "ethics", despite the lack of any practical or administrative barrier to their use. As noted earlier, the AMA's ethics held to be unlawful restraints of trade just recently in *In re American Medical Association, supra,* made it unethical for physicians to enter into contracts "which affect the adequacy of fees, involve underbidding, or preclude free choice of physician." 94 F.T.C. at 1012. The two medical societies involved in this case as AMA affiliates were bound to follow and enforce these anticompetitive ethics for over 50 years. 94 F.T.C. at 997. The Respondent Maricopa County Medical Society was specifically found by the trial judge in *In re American Medical Assn., supra,* 94 F.T.C. at 830-33, to have used these ethics to combat competitive alternatives. Since strong insurer participating contracts could be expected to be vigorously opposed by local medical societies as "unethical", the foundations' agreements were in many respects insures only alternative. Havighurst, *Professional Restraints on Innovation in Health Care Financing*, 1978 DUKE L.J. 303. Thus, it would be building antitrust violation upon antitrust violation to legitimatize the foundation or guild fee agreements.

Accordingly, even an American Medical Association attorney recognized as "one of the nation's foremost experts on health law" strongly recommends that medical societies stop any collective fee negotiations with insurers:

> Third-party plans need stabilized physicians' fees in order to determine premiums for medical and health insurance. Some medical societies have previously assisted in the process, but this is now quicksand. If you are running a committee to help third-party payers determine what is reasonable payment for physicians' services, stop.

> Third-party payers can themselves hire practicing physicians on a part-time basis, if they wish. But it should not be done by a medical society.

Breo, *Antitrust and the Medical Society*, 76 OHIO ST. MED. J. 136, 140 (March, 1980) (Emphasis added).

Therefore, close examination of the Respondents and their physician fee agreements reveals classic guild conduct wholly lacking in redeeming values and justification. Masked behind the high sounding labels "foundation", "cost containment", and "competitive alternative", are medical society guilds with overwhelming market power collectively bargaining over physician fee levels. Like a cancer, the medical guild model spreads to any part of the marketplace where price competition might break out among physicians. Its spread to the Respondents' foundation fee agreements should be halted now. Accordingly, the Court should hold these price-tampering agreements by medical professionals illegal under either a *per se* or truncated rule of reason analysis. *Goldfarb v. Virginia State Bar*, 421 U.S. 773 (1975); *National Society of Professional Engineers, supra.*

At the same time, the Court should make clear that the private market principles of the antitrust laws do not mean that every combination of physicians is illegal. Central to the illegality in this case is the overwhelming market power of 70% of the area physicians represented by Respondents. Smaller aggregations of health care providers offering new services and efficiencies are lawful so long as the loss of provider price competition between participants is not too great.

The guild mentality has created an erroneous "all or nothing" logic among physicians. Many doctors fear that the only alternative to "all" uniting in a guild is the other extreme, the individual physician facing large buyers alone. In fact, there is a vast middle ground of partial and full integrations among physicians that are judged by merger and joint venture standards and are perfectly lawful:

> [Arrangements] . . . where there is substantial but not complete integration of production, managerial, distribution, financial or other operations will be considered [joint ventures]. Without such integration, the "joint venture" label simply masks a consensual cartel, and there is no reason to displace established antitrust rules governing cartel conduct. And, of course, when there is complete or substantially complete integration between the parent companies, merger rules would apply.

Pitofsky, *Joint Ventures Under the Antitrust Laws: Some Reflections on the Significance of Penn-Olin,* 82 HARVARD L. REV. 1007, 1016 (1969).

Physicians in private practice do not have to give up their independent practices. They can partially integrate their practices and not be guilty of *per se* price fixing:

> [T]wo conditions. . .must be met before a partial integration reducing price competition escapes *per se* treatment. The first is that the price restraint must arise inevitably from the integration.* * * *
>
> * * * *
>
> The second contition to be met before a partial integration which ends price competition escapes the *per se* ban is one which requires the court to look at structure at least in a truncated way. If the arrangement appears likely to dampen price competition market-wide by ending price competition between participants, it will be *per se* unlawful despite the integration.

L. SULLIVAN, *supra,* at 208-09.

There is a vast area where the private market for medical care can function properly with price competition among

health care providers. In it, physicians can group together in a variety of forms and arrangements as long as provider price competition and incentives for efficiency are preserved.

In the final analysis, market principles apply to medical care not because there are no differences between medical services and cars, steel, airplanes, tires and computers, but because all have one thing in common: the economic question of the best allocation of society's limited resources. Given the dilemma that society's resources are not infinite, there are only three basic ways of allocating scarce economic resources – competition, government regulation, and a combination of both. No choice is problem-free, and all have their drawbacks. To avoid extensive government regulation of medical practice, price competition among physicians and other providers is the only alternative. Price competition imposes the discipline on private markets without which free markets cannot operate.

The Respondents' foundation fee agreements perpetuate a guild model of medical health care delivery and inhibit price competition among physicians, and should, therefore, be struck down by this Court. Once freed from the shackles of guild thinking, a properly functioning private market for health care is possible and preferable for consumers and providers alike.

CONCLUSION

For the foregoing reasons, the decision of the Ninth Circuit should be reversed, and summary judgment granted in favor of Petitioner, State of Arizona.

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OCTOBER TERM, 1980

STATE OF ARIZONA, PETITIONER

v.

MARICOPA COUNTY MEDICAL SOCIETY, ET AL.

ON WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE NINTH CIRCUIT

BRIEF FOR THE UNITED STATES AS AMICUS CURIAE

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QUESTION PRESENTED

Whether an agreement among competing physicians setting maximum prices to be paid by insurance companies for services provided by physicians to insured patients is illegal per se under Section 1 of the Sherman Act.

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In the Supreme Court of the United States

OCTOBER TERM, 1980

No. 80-419

STATE OF ARIZONA, PETITIONER

v.

MARICOPA COUNTY MEDICAL SOCIETY, ET AL.

ON WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE NINTH CIRCUIT

BRIEF FOR THE UNITED STATES AS AMICUS CURIAE

INTEREST OF THE UNITED STATES

The United States, which has primary responsibility for enforcing the federal antitrust laws, has a substantial interest in protecting the economy against anticompetitive price fixing activities. It also has a substantial interest in defining the circumstances in which the per se rule against price fixing is applicable. As part of its effort to promote rational enforcement of the antitrust laws, the United States has participated as amicus curiae before this Court in other private antitrust cases involving the proper application of the per se rule. See, *e.g.*, *Catalano, Inc.* v. *Target Sales, Inc.*, 446 U.S. 643 (1980); *Broadcast Music, Inc.* v. *Columbia Broadcasting System, Inc.*, 441 U.S. 1 (1979).

STATEMENT

1. Respondents Maricopa Foundation for Medical Care and Pima Foundation for Medical Care are associations of doctors that approve, set maximum payment levels for, and assist in the administration of prepaid health insur-

ance plans underwritten by private insurers (Pet. App. 2-3, 39).[1] Membership in the foundations is open to all physicians licensed in Arizona (*id.* at 3). More than seventy percent of the practicing physicians in each of Maricopa and Pima Counties are members of the respective foundations (J.A. 407; C.R. 7(a), Ex. PF-125).[2] Seven insurers that do business in Arizona operate foundation-approved insurance plans (C.R. 7(b), Ex. MF-90).

In order to obtain and retain foundation approval, an insurer must agree that it will pay member physicians for medical services to insured patients up to the maximum amounts specified by the foundation (Pet. App. 42-43; Br. in Opp. 4; J.A. 129-130).[3] The maximum fees that the insurers must pay are set by majoriy vote of each foundation's member physicians on proposals made by the foundation's board of trustees (Pet. App. 2, 39).[4] As

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[1] Under "prepaid" plans approved by the foundations, economically independent participating physicians agree to bill insurers directly rather than billing patients. Under "indemnity" plans, in contrast, patients pay the bills and then seek reimbursement from their insurers.

[2] "C.R." refers to the clerk's record in the district court. Maricopa County includes the city of Phoenix. Pima County includes the city of Tucson. The population of Maricopa County is 1,508,030; the population of Pima County is 531,263. The total population of the State of Arizona is 2,717,866. Bureau of the Census, *1980 Census of Population & Housing: Advance Reports PHC 80-v-4* (March 1981).

[3] Physicians are paid on a fee-for-service basis according to the number and type of services rendered. There are no limits on total insurer payments to a physician.

[4] The foundations "use relative value schedules and conversion factors to determine the maximum reimbursable levels of compensation for medical services provided to patients insured under foundation endorsed health insurance plans" (Br. in Opp. 5-6). A "relative value schedule" is a list that gives each medical service a numerical unit designation expressing its value in relation to other services. Conversion factors are dollar amounts by which the relative values are multiplied to create a list of fees. See generally Havighurst and Kissam, *The Antitrust Implications of Relative Value Studies in Medicine*, 4 J. Health Politics, Policy and Law 48 (1979); Bureau of Competition, Federal Trade Commission, *Medical*

the foundations acknowledge, revisions of the maximum fees occur when the board of trustees "feels they have fallen so far below usual and customary fees that physicians will resign from or refuse to renew membership in the foundation if they are not revised" (Br. in Opp. 4). To determine what its revised maximum fees should be, each foundation's board surveys physicians—including those who are not foundation members—and inquires about their usual and customary fees (Br. in Opp. 4; C.R. 7(b), Ex. MF-3, MF-6, reproduced in petitioner's Reply Memorandum, Exs. B, C).[5] In 1979, eighty-five to ninety-five percent of the physicians in Maricopa County billed at or above the Maricopa Foundation's maximum reimbursement levels, which were adopted in 1977 (Pet. App. 3; Br. in Opp. 8 n.24).

Subscribers to foundation-approved insurance plans individually select the physicians from whom they will receive medical care (Br. in Opp. 5). Foundation member physicians agree that they will accept the approved insurers' payments as full compensation for their services, *i.e.*, they agree not to seek additional payments from their patients who are covered by foundation-approved insurance (*id.* at 3, 6).[6]

Participation in Control of Blue Shield and Certain Other Open-Panel Medical Prepayment Plans 128 (1979).

[5] As the President of the Maricopa Foundation stated in a 1977 letter soliciting fee information (C.R. 7(b), Exhibit MF-33, reproduced in petitioner's Reply Memorandum, Appendix A): "The Maricopa Foundation for Medical Care is interested in maintaining as close-as-possible a relationship between the maximum allowance for Foundation plans and the usual and customary charges made by physicians in this area." In a 1974 letter to doctors urging them to renew their foundation membership (C.R. 7(b), Ex. MF-90), the Maricopa Foundation summarized its "progress" between 1970 and 1974. It noted that its "percent of increase" in the "maximum fee schedule" ranged between 30 and 33% for covered medical services.

[6] Persons insured under foundation-approved plans are not required to obtain medical services from member physicians (Br. in Opp. 5). Charges of nonmember physicians are paid by insurers up to the foundation-prescribed maximums, but such physicians need not accept those amounts in full satisfaction of their charges and may bill patients for the balance of any fee (*id.* at 5-6).

In addition to setting maximum fees, the foundations perform two other functions in conjunction with approved insurance plans: (1) peer review, *i.e.*, evaluating the necessity and appropriateness of treatment and hospital services rendered to insured patients, and (2) insurance administration, *i.e.*, serving as agents for underwriters and drawing funds from insurers' accounts to pay doctors' bills (Pet. App. 3). Respondents have not asserted that performance of either of those functions requires that doctors set the maximum fees that insurers must pay.

2. In 1978, the State of Arizona brought suit in the United States District Court for the District of Arizona, seeking injunctive relief against the two respondent foundations, the Maricopa County Medical Society, and the Pima County Medical Society.[7] The complaint alleged that the foundations were engaged in price fixing, in violation of Section 1 of the Sherman Act, 15 U.S.C. 1. Arizona moved for summary judgment on the issue of liability, asserting that maximum price fixing agreements are illegal per se.

The respondent foundations admitted that, by vote of their member physicians, they set the maximum prices that insurers must pay for services rendered to insured patients (Pet. App. 2, 39; J.A. 123, 126). They denied, however, that this constituted illegal "price fixing" (Br. in Opp. 7). While the foundations argued that the foundation plans were procompetitive because they provided an alternative type of health care coverage, and that foundation plans that used maximum fee agreements were effective in containing health care costs, they did not assert that prepaid insurance coverage or cost containment required that member doctors set the maximum amounts that insurance companies must pay.

The district court denied Arizona's motion for summary judgment on the issue of liability (Pet. App. 48).

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[7] The Pima County Medical Society was later dismissed under a consent order (Pet. App. 2 n.2).

Although it noted that "[p]rice-fixing has for some time been viewed as per se unlawful" (*id.* at 43), the court refused to apply a per se rule to the conduct at issue for two reasons. First, it perceived "a recent antitrust trend [that] appears to be emerging where the Rule of Reason is the preferred method of determining whether a particular practice is in violation of the antitrust law" (*id.* at 43-44). Second, it considered the per se rule inapplicable because members of a profession were involved in the allegedly illegal conduct (*id.* at 45-47). The district court nonetheless certified to the court of appeals the question whether the rule of reason should be used in analyzing the foundations' price fixing activities (*id.* at 50-51).

On appeal, the foundations argued that a rule of reason analysis was required because the "antitrust laws were not intended to straightjacket imaginative experimentation in fields, such as the professions, not traditionally subject to antitrust scrutiny" (Brief of Defendant-Appellee Maricopa Foundation for Medical Care at 36).[8] They also asserted (*id.* at 38-39) that the Ninth Circuit's decision in *Catalano, Inc.* v. *Target Sales, Inc.*, 605 F.2d 1097 (1979), rev'd and remanded, 446 U.S. 643 (1980), required a rule of reason approach. The foundations further contended that the challenged price agreements were not illegal because they would not necessarily affect the fees charged to patients. Finally, the foundations cited this Court's decision in *Broadcast Music, Inc.* v. *Columbia Broadcasting System, Inc.*, 441 U.S. 1 (1979), in support of their argument that the per se rule against price fixing was inapplicable. At no time, however, did they attempt to demonstrate that price fixing agreements among competing doctors are necessary to any cooperative productive activity of the foundations.

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[8] Pima Foundation for Medical Care joined in this brief in the court of appeals.

The court of appeals affirmed the district court's decision by a divided vote (Pet. App. 1-32). The court recognized that the agreements at issue in this case are horizontal agreements among competing physicians to set maximum fees that insurers must pay (*id.* at 2). It also recognized that, under this Court's decisions, price fixing, including vertical maximum price fixing, is illegal per se (*id.* at 7 n.4). Since the agreements at issue were maximum price agreements among direct competitors, however, the court of appeals did not believe that it was bound by prior decisions of this Court applying the per se rule. In addition, the court of appeals referred to the "professional" nature of the services provided by the foundations (*id.* at 5-6), and stated that "a restraint may serve the public, the transcendent end of all professions, even though its presence in a purely commercial setting would violate the antitrust law[s]" (*id.* at 12). Finally, the court asserted that the per se rule was inapplicable because the "record reveals nothing about the actual competitive effects of the challenged arrangement" (*id.* at 5).[9]

Judge Larson dissented. He concluded that the fee setting agreements among physicians are the type of "naked price restraint" previously held by this Court to be illegal per se. He observed that nothing in the nature of the medical profession or the health care industry warrants an exception from per se rules against price fixing (Pet. App. 19-27). Judge Larson also concluded that, "[e]ven if this were the first judicial examination of this form of restraint, its anticompetitive vices are egregious and its procompetitive features nonexistent, so that this Court could declare it to be within the per se rules" (*id.* at 27).[10]

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[9] What the court meant by evidence of "actual competitive effects" apparently was evidence that the fees paid to doctors would be less in the absence of the maximum fee schedules fixed by the foundations (see Pet. App. 6, 30-31).

[10] Judge Larson added that "even if the rule of reason is the correct standard * * * a detailed economic analysis of the industry

SUMMARY OF ARGUMENT

A. This Court consistently has applied a per se rule in holding horizontal price fixing agreements unlawful under Section 1 of the Sherman Act. *United States* v. *Trenton Potteries Co.*, 273 U.S. 392, 397-399 (1927); *United States* v. *Socony-Vacuum Oil Co.*, 310 U.S. 150, 223 (1940); *Catalano, Inc.* v. *Target Sales, Inc.*, 446 U.S. 643 (1980). The per se rule has been deemed applicable to maximum as well as minimum price agreements. *Kiefer-Stewart Co.* v. *Joseph E. Seagram & Sons, Inc.*, 340 U.S. 211, 213 (1951); *Albrecht* v. *Herald Co.*, 390 U.S. 145, 152-154 (1968).

B. Horizontal maximum price agreements only rarely have legitimate purposes and typically pose significant dangers to competition. Such agreements may be minimum price agreements in disguise. Moreover, even when they do not begin as such, they are likely to have the long-run effect of raising prices above a competitive level, for sellers have strong incentives to use the economic power aggregated through the agreements to further their own economic interests.

C. The reasons advanced by the court of appeals for remanding the case for a rule of reason trial are inconsistent with this Court's decisions and would impose on the district court a regulatory task it is ill-equipped to perform. A price fixing agreement is not exempt from speedy condemnation merely because the physicians who are parties to it are professionals. *Goldfarb* v. *Virginia State Bar*, 421 U.S. 773, 788 (1975); *National Society of Professional Engineers* v. *United States*, 435 U.S. 679, 696 (1978). Nor do escalating costs of health care warrant a rejection of established antitrust principles. In the health care industry, as in other industries, the level

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is not necessary. This agreement to fix fees is so plainly anticompetitive that it is an unreasonable restraint of trade on its face" (Pet. App. 31-32). Arizona's motion for summary judgment on liability based on the rule of reason also had been denied by the district court (Pet. 6; Br. in Opp. 10).

of prices fixed by an agreement among competitors is not relevant to a determination of the agreement's legality under the Sherman Act. *Catalano, Inc.* v. *Target Sales, Inc., supra*, 446 U.S. at 647; *United States* v. *Trans-Missouri Freight Ass'n*, 166 U.S. 290, 340-341 (1897); *United States* v. *Socony-Vacuum Oil Co., supra*. Moreover, an inquiry into an agreement's actual effect on prices over the long term would impose on the district courts a continuing "ratemaking" burden which they are not equipped to sustain. *United States* v. *Trenton Potteries Co., supra*, 273 U.S. at 397-398. Finally, the court of appeals' assumption that price fixing by sellers, who have not integrated their productive capacity, is an acceptable means to correct deficiencies in the competitive marketplace conflicts with this Court's conclusion that it is solely the province of legislatures, not private groups, to decide when the public interest requires allocation of resources by some method other than competition. *National Society of Professional Engineers* v. *United States, supra*, 435 U.S. at 695-696.

D. When a court is confronted with a horizontal maximum price fixing agreement, its initial inquiry—which may be denominated either a "quick look" to determine the applicability of the per se rule or a limited rule of reason inquiry—must focus on determining whether the proponents of the agreement have shown it to be necessary to some integration of productive capacity. If they have not, the price agreement should be deemed to have no effect other than restraining competition and should be held "illegal on its face." *National Society of Professional Engineers* v. *United States, supra*, 435 U.S. at 692.

E. This type of limited inquiry reveals that the agreements at issue in the present case are illegal on their face. Respondents have not identified any reason why the legitimate activities of the foundations require competing doctors to agree on prices. Thus, the restraint on price competition is not necessary to any integration of productive capacity. In addition, the maximum price agreements at issue have the practical effect of minimum

price agreements. Once an insurer agrees to pay the prices fixed by the foundations, no doctor has a financial incentive to charge less than those prices for services rendered to insured patients. Finally, maximum price agreements among a substantial percentage of the doctors in a community—here more than seventy percent—frustrate the development of insurer-imposed limitations on prices that would promote rather than impair competition. Instead of being faced with prices set by a powerful combination of sellers, insurers, like other buyers, should have access to a competitive market. The economic benefits of price competition which then would accrue to insurers could be passed on to their subscriber customers.

ARGUMENT

A. This Court's Decisions Establish That Maximum Price Fixing By Competitors Is Illegal Under The Federal Antitrust Laws Unless Necessary To Cooperative Productive Activity

The complaint in this antitrust case, filed by the State of Arizona, seeks to enjoin the enforcement of horizontal agreements among hundreds of doctors that directly fix the maximum prices they charge to insurance companies. The price fixing agreements are implemented through foundations that include more than seventy percent of the practicing physicians in the two most populous counties in Arizona.[11] The members of the foundations are independent practicing physicians.[12] They agree by

[11] When the Maricopa Foundation for Medical Care was incorporated in 1969, it initially enrolled 80 percent of the practicing physicians in Maricopa County (J.A. 407). Its membership consistently has been in excess of 70 percent of the practicing physicians in the County (*ibid.*); at times it has exceeded 90 percent (C.R. 7(b), Ex. MS-1). The percentages are similar for the Pima Foundation (C.R. 7(a), Ex. PF-125). In 1974, the Maricopa Foundation had 899 physician members (C.R. 7(b), Ex. MF-90), and the Pima Foundation had 400 physician members (C.R. 7(a), Ex. PF-125).

[12] The agreements at issue in this case differ fundamentally from the kinds of agreements that facilitate the operation of health

majority vote on the maximum prices that insurance companies must pay if they wish to do business with the foundations.[13] The insurance companies are required to pay any fee up to the prescribed maximums for medical services rendered to subscribers of foundation-approved insurance plans (Pet. App. 2; Br. in Opp. 2). We submit that Judge Larson correctly concluded, in view of the record before him (Pet. App. 31), that "[b]ased on an assessment of its competitive impact," this mechanism to prescribe the maximum fees that purchasers of medical services must pay "should be sub-

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maintenance organizations ("HMOs"). The member physicians of the defendant foundations practice as separate economic entities who have not integrated their medical practices or entered into any risk-sharing arrangements. By contrast, the Health Maintenance Organization Act of 1973, 42 U.S.C. 300e *et seq.*, provides that, in a health maintenance organization, a group of physicians and other health professionals may provide coordinated and integrated comprehensive medical services to subscribers for a periodic fee. Physicians in an HMO share income (from subscriber fees) and expenses according to employment or partnership agreements and usually are at risk for any adverse financial results of the HMO. Under those circumstances, agreements among participating doctors about the fees to be charged and the salaries or partnership shares to be paid to physicians and others who provide services through an HMO, like similar agreements among individuals who form a partnership or joint venture, may be essential to render the service provided by the HMO. See *United States* v. *Addyston Pipe & Steel Co.*, 85 F. 271, 281-282 (6th Cir. 1898) (Taft, J.), aff'd as modified, 175 U.S. 211 (1899). See also pages 19-24, *infra*.

[13] Respondents argue that their agreements do not fix prices because "[a]ll physicians are free to bill as they like" (Br. in Opp. 6). But freedom to bill an amount that one has agreed not to collect has no economic significance (see Pet. App. 42-43). Even if the agreements did not fix a maximum for "billed prices," they would still fix a maximum for real prices—*i.e.*, the prices doctors charge insurers. Moreover, since any price-fixing agreement that violates the Sherman Act is legally unenforceable, the pertinent consideration is not the theoretical freedom of action the parties to the agreement legally retain, but the constraint to which they have agreed in the exercise of that freedom.

ject to the per se standards traditionally applied to price-fixing." [14]

The antitrust laws rest on the premise that a competitive market system will result in an optimal allocation of resources. Accordingly, the fundamental issue in any case under Section 1 of the Sherman Act is whether the agreement at issue promotes competition or undermines competition. *National Society of Professional Engineers* v. *United States*, 435 U.S. 679, 691 (1978). In construing and applying Section 1, however, this Court "has held that certain agreements or practices are so 'plainly anti-competitive,' * * * and so often 'lack * * * any redeeming virtue' * * * that they are conclusively presumed illegal without further examination." *Broadcast Music, Inc.* v. *Columbia Broadcasting System, Inc.*, 441 U.S. 1, 8 (1979). Such agreements are described as being illegal per se.

This Court long ago established that a horizontal minimum price fixing agreement among competitors with respect to the prices to be charged for their products or services is a per se violation of Section 1. *United States* v. *Trenton Potteries Co.*, 273 U.S. 392, 397 (1927); *United States* v. *Socony-Vacuum Oil Co.*, 310 U.S. 150, 223 (1940). The continuing validity of the per se rule was reaffirmed just last year. *Catalano, Inc.* v. *Target Sales, Inc.*, 446 U.S. 643, 647 (1980).[15]

The Court's opinions have not limited the per se rule against price fixing to agreements that set a uniform or minimum price. "Under the Sherman Act a combination

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[14] Respondents argue that their agreements do not fix prices because they apply only to payments by foundation-approved insurers to foundation member doctors. However, a showing that the effect of the agreements was limited to transactions with insurers would provide no defense. Price fixing agreements are illegal per se even if they "may not be aimed at complete elimination of price competition." *United States* v. *Socony-Vacuum Oil Co.*, 310 U.S. 150, 225 n.59 (1940).

[15] In *Catalano*, this Court summarily reversed a decision of the Ninth Circuit which had held that an agreement among competitors to eliminate free trade credit did not constitute price fixing and consequently was not per se illegal.

formed for the purpose and with the effect of raising, depressing, fixing, pegging, or stabilizing * * * price * * * is illegal *per se*." *United States* v. *Socony-Vacuum Oil Co., supra*, 310 U.S. 223. Thus, the Court has indicated that agreements to fix maximum prices are illegal per se. *Kiefer-Stewart Co.* v. *Joseph E. Seagram & Sons, Inc.*, 340 U.S. 211, 213 (1951); *Albrecht* v. *Herald Co.*, 390 U.S. 145, 152-154 (1968). In *Kiefer-Stewart*, the agreement at issue was viewed as horizontal as well as vertical, even though the defendants were affiliated enterprises. In that context, the Court ruled that "agreement[s] *among competitors* to fix *maximum* * * * prices of their products * * * no less than those to fix minimum prices * * * [are] * * * illegal *per se*." 340 U.S. 213 (emphasis added). These principles provide the starting point for analysis in this case.

B. Maximum Price Fixing Agreements Among Competitors Pose A Serious Threat To Competitive Conditions

Compelling economic reasons support this Court's conclusion that horizontal agreements to fix maximum prices generally are illegal under the antitrust laws. In a competitive economy, buyers and sellers are motivated by financial self-interest. It is socially beneficial that each seller strive independently to obtain the best possible price for his product or service. A seller may, of course, misjudge what his profit-maximizing price is, and thus temporarily underprice or overprice his product. But few sellers willingly would enter into an agreement requiring them to take less for their products or services than could be obtained under prevailing market conditions.[16]

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[16] There is one possible exception to this observation, but it reinforces the traditional rule against maximum price fixing. Sellers with dominant market power might believe it to be in their economic interest to decrease prices in the short run—that is, to maintain prices above a competitive level but at less than the monopoly price they would be able to command—in order to discourage new entry and thus preserve supra-competitive prices. Such anticom-

While there is little incentive for sellers to band together to keep their prices below a competitive level,[17] there is a direct and substantial incentive for them to combine to raise prices to a supra-competitive level. That incentive to restrict output and raise prices by agreement is the central concern behind Section 1 of the Sherman Act. Because sellers have an incentive to agree to raise prices, there is a dangerous probability that agreements among competing sellers to fix maximum prices in reality are agreements to fix minimum prices, or are likely to be used to do so over time. See *Albrecht* v. *Herald Co.*, *supra*, 390 U.S. at 153, where the Court, in discussing a vertical maximum price fixing arrangement, noted that "if the actual price charged under a maximum price scheme is nearly always the fixed maximum price * * * the scheme tends to acquire all the attributes of an arrangement fixing minimum prices." That risk is greatest when the defendants possess substantial market power, as they do in this case.[18]

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petitive behavior was found to exist in *American Tobacco Co.* v. *United States*, 328 U.S. 781, 806-807 (1946); see also L. Sullivan, *Antitrust* § 78 at 211 (1977); Comment, *The Per Se Illegality of Price Fixing—Sans Power, Purpose, or Effect*, 19 U. Chi. L. Rev. 837, 846 & n.55 (1952). This concern is not immaterial in the medical service industry. See generally, Halper, *The Health Care Industry and the Antitrust Laws: Collision Course?*, 49 Antitrust L.J. 17, 20, 22 (1980), describing the "many physician group efforts to discourage development of HMOs," and noting that physician groups have not proven immune to "fears of a new form of competition, or any competition at all, that could take away patients, put pressure on fees, or change the accepted economics of physician practice."

[17] Of course, an individual seller who wished to sell below the competitive price to a particular customer for "altruistic" reasons would have no need to combine with his rivals to do so.

[18] The court of appeals in this case was of the view that an extensive economic analysis was called for because the agreements at issue are horizontal, while the agreements treated as illegal per se in this Court's past decisions were vertical. In adopting that view, the court of appeals not only overlooked *Kiefer-Stewart's* statement that maximum price fixing by *competitors* is illegal per

The danger that horizontal maximum price agreements will allow sellers to increase their prices above a competitive level takes two principal forms. First, the so-called maximum price fixing agreement may be a sham and really be no more than a convenient cover for a classic cartel arrangement to fix minimum prices. Second, even if the participants are initially well-intentioned and do not start by fixing minimum prices, they have the power to do so. See *United States* v. *Trans-Missouri Freight Ass'n*, 166 U.S. 290, 324 (1897) ("it is not material that the price of an article may be lowered. It is in the power of the combination to raise it"). Changing circumstances will call for adjustments in the initially prescribed maximum price that buyers must pay. See page 3, *supra*. At such time, in view of the normal economic incentive to increase profits, it is unlikely that the participants in the agreement would continue to exercise their market power in an altruistic manner. This Court long ago recognized that danger in *United States* v. *Trenton Potteries Co.*, *supra*, 273 U.S. at 397-398:

> The power to fix prices, whether reasonably exercised or not, involves power to control the market and to fix arbitrary and unreasonable prices. The reasonable price fixed today may through economic and business changes become the unreasonable price of tomorrow. * * * Agreements which create such potential power may well be held to be in themselves unreasonable or unlawful restraints, without the necessity of minute inquiry whether a particular price is reasonable or unreasonable as fixed and without placing on the government in enforcing the

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se, but also reached a result opposite to that which could be drawn from economic analysis. Economically, there is a stronger case for per se treatment of horizontal maximum price agreements. Restrictive vertical agreements have a potential for procompetitive effects that exceeds that of horizontal agreements. See *Continental T.V., Inc.* v. *GTE Sylvania Inc.*, 433 U.S. 36, 51-52, 56-59 & n.28 (1977). A more detailed analysis, therefore, may be appropriate to determine whether certain vertical restraints should be held unlawful.

> Sherman Law the burden of ascertaining from day to day whether it has become unreasonable * * *.

Accordingly, in a case in which the challenged agreement among competitors to fix prices is not a necessary element of cooperative productive activity—such as a partnership or joint venture that creates efficiencies by integrating the economic functions of its members—the decisions of this Court properly characterize the agreement as a naked restraint illegal per se under the antitrust laws. See note 12, *supra*.

C. The Illegality Of Maximum Price Fixing Agreements Is Not Affected By The Fact That The Defendants Are Participants In The Health Care Industry

1. The court of appeals hesitated to find the agreements at issue in this case illegal on their face because it was uncertain about the extent to which the Sherman Act applies to professionals, and because it had difficulty in discerning the "competitive order that should exist within the health care industry" (Pet. App. 5). But the fact that the parties to the agreements are doctors does not, by itself, justify the court of appeals' refusal to determine the legality of their action on the basis of settled principles of antitrust law as applied to the undisputed facts before it. The court's view that the public service goals of the medical profession warrant analysis different from that applicable to similar restraints imposed by other sellers (Pet. App. 12) conflicts with this Court's decisions in *Goldfarb* v. *Virginia State Bar*, 421 U.S. 773, 788 (1975), and *National Society of Professional Engineers* v. *United States*, *supra*, 435 U.S. at 696. Those cases hold that price fixing among competitors is not exempt from traditional antitrust analysis merely because the parties to the agreement are professionals. And nothing about the medical profession distinguishes it from the legal and engineering professions in any respect that would mitigate the anticompetitive effects of price fixing. See *American Medical Association* v. *United States*, 317 U.S. 519, 528 (1943), noting that "the calling or occupa-

tion of the individual physicians charged as defendants is immaterial if the purpose and effect of their conspiracy was * * * obstruction and restraint" of trade in the group health care industry.

2. The court of appeals also erred in concluding (Pet. App. 6-9) that, because the health care industry has special characteristics and does not operate as a purely competitive market, horizontal maximum price fixing agreements should be condoned if they have the effect of reducing medical fees. In suggesting that it is appropriate to consider the effect of the agreements on the level of price, the court of appeals apparently believed that a private restraint on competition (horizontal price fixing) could serve as an acceptable means to offset a perceived deficiency in the competitive characteristics of the health care industry.[19] Even in the short run, however, any such balancing process would create a "sea of doubt" on which the decisions of this Court wisely have refused to embark. See *National Society of Professional Engineers* v. *United States*, *supra*, 435 U.S. at 696. Neither economic analysis nor legal precedent would provide adequate guidance in applying such a balancing test.[20] Moreover, the court of appeals' approach would clash with this Court's decisions, which "foreclose the argument that be-

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[19] Effective competition in the health care industry can be diminished by consumer indifference to price resulting from insurance and other factors. See 42 U.S.C. (Supp. III) 300k-2(b)(1).

[20] If, due to perceived imperfections in competition, antitrust courts were free partially to displace competition or prescribe a mixture of competition and other conditions, they would enter the obscure world of "second best." See R. Bork, *The Antitrust Paradox* 113-114 (1978). Under such an approach, there would be "no criteria that could be applied by a court to the decision of individual cases." *Id.* at 113. For this reason, courts should not be empowered to decide "how much restraint of competition is in the public interest, and how much is not." *United States* v. *Addyston Pipe & Steel Co.*, *supra*, 85 F. at 284. "The manifest danger in the administration of justice according to so shifting, vague, and indeterminate a standard would seem to be a strong reason against adopting it." *Ibid.*

cause of the special characteristics of a particular industry, monopolistic arrangements will better promote trade and commerce than competition." *Id.* at 689.

Indeed, judicial inquiry into the effect on prices of maximum price agreements would be virtually impossible as a practical matter, for it would force antitrust courts to immerse themselves in voluminous price and output data without ascertainable standards for analysis. They would have to make the kind of judgments that rate regulating agencies make, but without statutory guidance, rulemaking power, or specialized expertise and staff. The measurement of reasonableness, moreover, would have to extend over time, as formal rate regulation does. Otherwise, parties to a maximum price agreement initially could restrain their prices and receive judicial approval, only to exercise their power to fix supra-competitive prices thereafter with impunity.[21] This Court repeatedly has recognized that district courts are not equipped to make this kind of inquiry. *United States* v. *Trans-Missouri Freight Ass'n*, *supra*, 166 U.S. at 323-324; *United States* v. *Trenton Potteries Co.*, *supra*, 273 U.S. at 397-398; *National Society of Professional Engineers* v. *United States*, *supra*, 435 U.S. at 689. With federal court dockets more crowded now than in the past, it makes even less sense to saddle the district courts with a new burden of essentially regulatory tasks. Since an inquiry into the level and reasonableness of price is judicially unmanageable, the legality of price fixing agreements cannot depend on a showing of unreasonable effect on price as the court of appeals envisioned. See *Catalano, Inc.* v. *Target Sales, Inc.*, *supra*, 446 U.S. at 647 ("[i]t is no excuse that the prices fixed are themselves reasonable"); see also F. Scherer, *Industrial Market Structure and Economic Performance* 438-440 (1970).

3. The court of appeals' further suggestion that the legality of horizontal price fixing agreements turns on

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[21] Evaluation of output, even if it were an adequate substitute for evaluation of price reasonableness, would itself be unmanageable: indeed, when services such as medical care are involved, the concept becomes almost metaphysical.

perceived inadequacies in the marketplace for medical services also is unsound as a matter of legal policy. If market forces do not result in a socially acceptable level of price or supply for particular services, state and federal legislatures may displace the competitive process with regulatory controls. See, *e.g.*, The National Health Planning and Resources Development Act of 1974, 42 U.S.C. (& Supp. III) 300k-l, 300m-2, 300m-6 and 300n-1(b) (encouraging the states to adopt certificate of need programs under which state agencies must approve new competitive entry by health care providers to avoid unnecessary duplication of services). But it is solely the province of the legislatures, not private groups, to decide when the public interest requires that economic resources be allocated by some means other than competition. *National Society of Professional Engineers* v. *United States*, *supra*, 435 U.S. at 695-696; see also *Standard Oil Co.* v. *FTC*, 340 U.S. 231, 248 (1951); *Fashion Originators' Guild* v. *FTC*, 312 U.S. 457, 463-468 (1941). Absent specific legislative action to supersede the Sherman Act,[22] private parties are bound by the

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[22] Respondents have not argued that any express or implied statutory immunity shields their price agreements from the antitrust laws. Moreover, recent legislation shows that Congress intended that competition in the health care industry should be encouraged and strengthened. See, *e.g.*, 42 U.S.C. (Supp. III) 300k-2(a)(17) (prescribing as a national health priority the "strengthening of competitive forces in the health services industry" when competition can serve the public interest); S. Rep. No. 96-96, 96th Cong., 1st Sess. 85 (1979) ("[health] planning agencies at all levels have as important a responsibility to promote competition among health care providers as the obligation to encourage cost containment, facility closure or shared services. The experience with other public regulatory authorities has been one of creating industry cartels which emphasize market stability rather than innovation and consumer preference. The Committee intends to protect against such tendencies in health sector regulation."); 42 U.S.C. (Supp. III) 300k-2(b)(1)-(3) (calling for promotion of competition when it can serve the public interest); 42 U.S.C. (Supp. III) 300l-2(a)(5) (directing health systems agencies to chart their course with a view

congressional mandate that prices must be the product of competition and not of private compacts among sellers.[23]

D. Horizontal Maximum Price Fixing Agreements Should Be Declared Illegal Without Further Judicial Examination Unless The Defendants Establish That Their Agreements Are Necessary To Cooperative Productive Activity

1. *a.* The per se rule plays an important role in antitrust enforcement. It is applied appropriately to business practices that are usually anticompetitive or that have significant anticompetitive potential and little or no potential to foster competition. In such instances, with little cost to society, the per se rule makes the proscriptions of the Sherman Act more certain and predictable for all concerned and eliminates the need for protracted and costly economic investigations into the history, purpose and effect of restraints of trade in every case. *Broadcast Music, Inc.* v. *Columbia Broadcasting System, Inc., supra*, 441 U.S. at 8 n.11. Per se rules, however, also pose dangers, for if they are applied without reference to their rationale they can hinder competition by banning conduct with significant procompetitive potential and economic utility. See *Continental T.V., Inc.* v. *GTE Sylvania Inc.*, 433 U.S. 36, 57-58 (1977).

Therefore, when a court is confronted with a particular agreement that appears on its face to fall within a

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to "preserving and improving, in accordance with section 300k-2(b) of this title, competition in the health service area"). This statutory scheme is discussed in the government's brief amicus curiae in *National Gerimedical Hospital* v. *Blue Cross of Kansas City*, No. 80-802.

[23] See Rahl, *Price Competition and the Price Fixing Rule—Preface and Perspective*, 57 Nw. U. L. Rev. 137, 142 (1962) ("Those who find it difficult to accept a per se rule when applied to an agreement to hold prices down miss the point to the rule. The rule is grounded on faith in price competition as a market force."). See also *United States* v. *Container Corp.*, 393 U.S. 333, 338 (1969) ("Price is too critical, too sensitive a control to allow it to be used even in an informal manner to restrain competition").

per se rule, but which the defendants claim has some competitive justification, a preliminary factual inquiry may be necessary to determine if the per se rule should be applied. This inquiry is necessarily limited, for as this Court has cautioned, "[t]he scrutiny occasionally required [to determine whether the per se rule applies] must not merely subsume the burdensome analysis required under the rule of reason." *Broadcast Music, Inc.* v. *Columbia Broadcasting System, Inc., supra,* 441 U.S. at 19 n.33; see also *United States* v. *Trenton Potteries Co., supra,* 273 U.S. at 398, 400-401. The judicial focus of this preliminary scrutiny or "quick look" should be limited to ascertaining whether the proponents of the agreement have identified signficant procompetitive effects achieved through integration of productive capacity that are unattainable in the absence of the agreement. Only if such effects are found would further inquiry under the rule of reason be warranted.[24] Thus, if an agreement on price were necessary to cooperative economic activity, as in a true partnership, joint venture or merger, the elimination of price rivalry would be a facet of an integration of productive resources capable of yielding efficiencies beneficial to competition, and would require further analysis. In the absence of such a necessary relationship to integrated productive activity, however, an agreement among competitors fixing prices properly is deemed a naked restraint with no purpose other than elimination of rivalry. Such a restraint should be held "illegal on its face." *National Society of Professional Engineers* v. *United States, supra,* 435 U.S. at 692.[25]

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[24] Purported benefits that are not procompetitive would not be relevant even under the rule of reason. *National Society of Professional Engineers* v. *United States, supra,* 435 U.S. at 690 ("the inquiry is confined to a consideration of impact on competitive conditions").

[25] See R. Bork, *The Antitrust Paradox, supra,* at 267:

> None of this analysis in any way detracts from the merit of the per se rule. It simply argues that the rule can be made more beneficial by confining its scope to its rationale. Price-fixing and market-division agreements (and any other hori-

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b. The need to take a "quick look" before declaring an agreement illegal per se does not, of course, mean that an extended rule of reason analysis must be applied each time a new form of horizontal maximum price fixing is challenged under the Sherman Act. On the contrary, as this Court recognized in *Catalano, Inc.* v. *Target Sales, Inc., supra*, the fact that a particular kind of price agreement—in that case an agreement to eliminate free credit—has never been the subject of Sherman Act adjudication does not preclude condemnation of the practice as illegal per se following a quick look. Thus, in *Catalano* the Court determined that the agreement to eliminate free credit foreclosed one type of price competition. It then looked to see whether any justifications relied on by the court of appeals required further analysis. 446 U.S. at 646 n.8. Finding no "procompetitive justification," the Court applied the per se rule. Accordingly, if, as in *Catalano*, a preliminary scrutiny of the procompetitive justifications offered by defendants in a horizontal maximum price fixing case does not indicate that the agreement is necessary to " 'increase economic efficiency and render markets more, rather than less, competitive,' " [26] expeditious condemnation, under whatever

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zontal agreements eliminating competition) should be illegal per se when they do not accompany a contract integration or are not capable of contributing to its efficiency. This is not to suggest that every ancillary restraint should be lawful. A showing that a restraint is ancillary, in the sense just stated, merely lifts it out of the per se category and subjects it to the other tests of the rule of reason: market share and specific intent. A finding of ancillarity merely proclaims the presence of an economic integration that entitles the restraint to be judged on the same terms as horizontal mergers or internal growth, the reason being that the same need to weigh possible efficiencies against possible restriction of output is present. Competitively beneficial integration of economic functions may occur at both the production and distribution stages. See L. Sullivan, *Antitrust, supra*, § 77 at 206-208.

[26] *Broadcast Music, Inc.* v. *Columbia Broadcasting System, Inc., supra*, 441 U.S. at 20, quoting *United States* v. *United States Gypsum Co.*, 438 U.S. 442, 441 n.16; see also *National Society of Professional Engineers* v. *United States, supra*, 435 U.S. at 688.

label, is appropriate. There is no need to proceed to an elaborate or lengthy rule of reason inquiry.[27]

The critical requirement, of course, in applying Section 1 of the Sherman Act to maximum price fixing agreements is to focus on economic reality. Debate about the "per se" and "rule of reason" labels should not obscure the fact that horizontal maximum price fixing agreements have great anticompetitive potential, and should be declared illegal as naked restraints without extensive judicial inquiry except in those rare cases where they are essential to the operation of integrated productive activity.

2. As Judge Larson noted in his dissenting opinion in the court of appeals (Pet. App. 31), application of the "rule of reason" to maximum price fixing agreements would not significantly alter the substance of the analysis. Even under the rule of reason, "a detailed economic analysis of the industry is not necessary" (*ibid.*).

The per se rule and the rule of reason are not unrelated or conflicting standards but "two complementary categories of antitrust analysis." *National Society of Professional Engineers* v. *United States*, *supra*, 435 U.S. 692. As this Court has cautioned, "the Rule [of Reason] does not open the field of antitrust inquiry to any argument in favor of a challenged restraint that may fall

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[27] Where defendants fail to show that any genuine issue of material fact remains in dispute, plaintiffs are entitled to summary judgment. See Fed. R. Civ. P. 56(e). For this Court to accept respondents' suggestion that the issue whether there has been a violation of Section 1 cannot be decided because "[t]his action has not advanced beyond motions for summary judgment, discovery has not been completed and there has been no trial on the merits" (Br. in Opp. 2) and "that this litigation [should] be permitted to follow its natural course and proceed to trial" (*id.* at 25), would be contrary to Rule 56 and would serve only to waste the resources of the parties and the courts and further delay the injunctive relief to which Arizona may be entitled. See *First National Bank of Arizona* v. *Cities Service Co.*, 391 U.S. 253, 284-290 (1968); see also *Catalano, Inc.* v. *Target Sales, Inc.*, *supra*, 446 U.S. at 643-644, 646 & n.8 (summarily rejecting meritless justifications for price fixing and applying the per se rule at a pretrial stage in the litigation).

within the realm of reason. Instead, it focuses directly on the challenged restraint's impact on competitive conditions." *Id.* at 688. Thus, the rule of reason requires a court to weigh the injury to competition that may result from the agreement at issue against any enhancement of competition that could not be achieved without the restraint. The court thereby determines whether "the restraint imposed is such as merely regulates and perhaps thereby promotes competition or whether it is such as may suppress or even destroy competition." *Chicago Board of Trade* v. *United States*, 246 U.S. 231, 238 (1918).

Accordingly, the rule of reason analysis in a horizontal maximum price fixing case would require that the plaintiff first establish that the challenged practice is an agreement among competitors fixing maximum price. If the plaintiff satisfied that burden, the court, without inquiry into actual effect on price, would recognize the dangers to competition posed by the agreement, *i.e.*, that, in some contexts, such agreements actually set minimum prices and, in many other contexts, they confer power to raise prices in the future (see pages 12-15, *supra*). The burden would then shift to the defendants to show that their agreement is essential to integrated productive activity and thereby yields efficiencies and procompetitive benefits which outweigh those dangers. If the defendants fail to do so, or if a review of the purported justifications reveals them to be without merit, the limited rule of reason inquiry—which in this situation would be no different from the "quick look" required to hold that the maximum price agreement is subject to a per se rule—would be at an end. It would then be clear that the agreement restrains competition without offsetting competitive benefits and is therefore illegal under Section 1. See R. Bork, *The Antitrust Paradox*, *supra*, at 267-269, 279.

If the defendants did demonstrate some significant procompetitive effect, the analysis would have to proceed further to determine the need for the challenged agreement and its overall economic impact in the factual situation before the court. But again, the analysis would be

no different from that under a sound application of the per se rule, for defendants who have made the showing of productive integration necessary to enable them to proceed beyond the initial stage of a rule of reason inquiry also have made a showing sufficient to avoid application of a per se rule following a "quick look."

In short, both the per se rule and the rule of reason focus on the impact of the challenged agreement on competitive conditions. In the absence of a showing that an agreement fixing maximum prices has a significant procompetitive effect due to its necessary relationship to cooperative productive activity, there is no reason for further judicial examination of the purported benefits of the agreement. It would be extremely wasteful of the resources of both courts and litigants if, as suggested by the court of appeals, district courts were required to attempt to ascertain the actual effect of horizontal maximum price fixing agreements on price levels over either the short or long run.[28]

E. The Maximum Price Fixing Agreements At Issue In This Case Are Illegal No Matter How They Are Analyzed

The agreements at issue, whether given a quick look under the per se rule or subjected to a limited inquiry under the rule of reason, violate Section 1 of the Sherman Act. Under either articulation of the appropriate criteria, respondents have failed to even suggest how the challenged price restraints could be deemed ancillary or necessary to a procompetitive venture. No further inquiry is required.[29]

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[28] As noted on pages 14-15, *supra*, such an inquiry would produce little information relevant to an examination of the competitive impact of a price fixing agreement. The level of prices, at any given point in time, cannot be dispositive since the agreement itself may confer market power which can be misused in the future. The only safeguard against that consequence would be to make the district courts "rate bureaus" with a continuing duty to monitor the prices fixed by all such agreements.

[29] Thus, the present case differs substantially from *Broadcast Music, Inc.* v. *Columbia Broadcasting System, Inc.*, *supra*, where

1. Respondents' assertion (Br. in Opp. 19) that their price fixing agreements promote competition by "offering an alternative to closed panel prepaid medical plans with foundation endorsed insurance" should be rejected. It is the medical insurance coverage provided by insurers, not the price fixing activities of doctors, that offers this competitive alternative. There is simply no reason to believe, and respondents offer no reason to believe, that maximum price fixing by physicians is necessary to the operation of health insurance plans that allow subscribers to choose their physicians. Insurers can, and often do, establish their own maximum payments to providers of medical services under plans that allow subscribers to choose their provider.[30] See generally *Group Life & Health Insurance Co.* v. *Royal Drug Co.*, 440 U.S. 205, 209-210 & n.5 (1979); see also the brief amicus curiae filed by the United States in the *Royal Drug Co.* case (77-952 Br. 10-13); Kallstrom, *Health Care Cost Control by Third Party Payors: Fee Schedules and the Sherman Act*, 1978 Duke L.J. 645, 661-665, 670, 678-684.

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a more detailed analysis under the rule of reason was justified because preliminary scrutiny disclosed that the challenged blanket license for musical compositions had a procompetitive effect and that its restraint on price competition was necessary to achieve that effect.

In *Broadcast Music, Inc.*, the blanket license at issue was found to be a unique product that improved the functioning of the market for the benefit of both buyers and sellers. At least for some customers, the desired product could be provided only on a collaborative basis. The challenged restraints on price competition, moreover, were inherent in the blanket license. Thus, this Court held that a rule of reason analysis was required to determine whether the commercial necessity of the blanket license in some types of transactions made it reasonably necessary in transactions with the plaintiffs. The lower courts were directed to balance the need for the blanket license against the anticompetitive effect of the license's pricing formula as applied to transactions with particular customers.

[30] In that case, of course, it is the individual *buyer* of services—*i.e.*, the insurer—rather than a cartel of sellers which prescribes a "low" price.

2. Respondents also suggest, as a "procompetitive justification," that "the effect of the foundation medical plans is to decrease the cost of medical service rather than to increase its cost" (Br. in Opp. 19). If by this they invite a judicial inquiry into the reasonableness of their prices, their invitation must be rejected. See page 17, *supra*. If they mean that the foundations' activities as a whole make it possible for doctors to provide medical care more efficiently, they would still have to show that *price fixing* was necessary to achieve the efficiency. For if the competitive benefits could be obtained without price fixing, there is no reason why society should accept the risk of anticompetitive abuse. Consequently, reference to competitive benefits will not save from per se condemnation restraints of trade that preliminary scrutiny shows to be unnecessary to achieve those benefits. See *United States* v. *Realty Multi-List, Inc.*, 629 F.2d 1351, 1374-1376 (5th Cir. 1980); *United States* v. *Addyston Pipe & Steel Co.*, 85 F. 271, 282-283 (6th Cir. 1898), aff'd as modified, 175 U.S. 211 (1899); L. Sullivan, *Antitrust* § 77 at 208-209 (1977); R. Bork, *The Antitrust Paradox*, 268, 279 (1978).

In this case only the price agreements themselves are challenged, and respondents have not contended that efficient functioning of peer review or claims administration [31] requires that the doctors collectively set maximum prices insurers must pay.[32] Indeed, the severability of these functions is demonstrated by the fact that the

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[31] The foundations perform "peer review" of the medical necessity and appropriateness of treatment given to insured patients and, for some groups, the necessity and appropriateness of hospital utilization (Pet. App. 3; Br. in Opp. 4). For some insured groups the foundations also serve as agents for underwriters to facilitate payments to doctors (Pet. App. 3; Br. in Opp. 4). The savings respondents claim as a result of the foundation plans (Br. in Opp. 4-5) appear to be at least partially attributable to these activities.

[32] It is not, of course, relevant that doctors might refuse to participate in other activities if they were enjoined from fixing prices (see Br. in Opp. 4). Illegal conduct cannot be immunized by the violators' threat to cease lawful activity if the illegal conduct is enjoined.

Maricopa Foundation itself has a contract with the State of Arizona to administer the Comprehensive Medical Dental Program for Foster Children, a program in which maximum payments to physicians are set by a state agency rather than by foundation members (Br. in Opp. 7). Accordingly, the legality of respondents' horizontal price fixing agreements must be determined solely by analysis of the likely competitive effect of price fixing, *i.e.*, without reference to the foundations' other activities that would not be impaired by an injunction against price fixing.[43]

3. *a.* Existing deficiencies in competition in the health care industry make the dangers to competition inherent in maximum price fixing agreements particularly acute. Indeed, because of those deficiencies there is a pressing

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[43] The maximum price agreements at issue in this case cannot be justified as a means of communicating information that could improve price competition or facilitate efficient development of prepaid insurance plans. As this Court recognized in *Catalano, Inc.* v. *Target Sales, Inc., supra*, 446 U.S. at 649, the "informing function" of a price fixing agreement cannot "justify its restraint on the individual wholesaler's freedom to select his own prices and terms of sale. For * * * it is obvious that any industrywide agreement on prices will result in a more accurate understanding of the terms offered by all parties to the agreement." The Court added that there is a "plain distinction" between advertising prices and fixing prices. *Id.* at 649-650. Moreover, in this case, the only information communicated to patients by a doctor's participation in the foundation is that the doctor's fee will be paid by the insurer. The only information communicated to insurers by the fee schedule is that foundation members will not do business unless insurers agree to pay fees up to the collectively-determined maximum prices. The fee agreements do nothing to communicate the information that insurer-buyers really need: How many and which doctors would do business at prices below those set by the foundations? In the absence of maximum fee agreements, there would be no significant difficulty in establishing efficient communication between doctors and insurers. Insurers would be free to prepare their own maximum price schedules and offer them to individual doctors or small groups of doctors working together to provide related medical services. See page 29, *infra*. Horizontal fee agreements among doctors, however, make it unlikely that such competitively beneficial information will be obtained by insurers.

need to eliminate restraints that might impede adoption of more competitive alternatives. In this context, once an insurer agrees to pay up to the maximum prices set by the foundations, the insurer's ability to obtain medical services at lower prices is foreclosed. No individual doctor has a financial incentive to charge less than the maximum fee for any service to insured patients. To do so would reduce his profit on each service, but it would not result in any corresponding increase in the volume of his business. Insurers, under the terms of the agreements with the foundations, cannot require patients to use a particular doctor. They cannot therefore shift business from a doctor who charges the maximum to a doctor who charges a lower price for the same service. It is the insured patient who selects the physician, and such a patient has no financial incentive to search for a doctor who charges less than the maximum. The doctor's fee is paid directly by the insurer, and an individual patient's insurance premiums are not reduced if he selects a less expensive doctor. In short, a doctor acting in his own economic interest—as the antitrust laws assume he will—has no financial incentive to charge an insurer less than the maximum price.[34]

Maximum price agreements among doctors who have substantial market power—as is true here—also may make it easier for them to increase prices by providing a uniform floor from which to seek upward adjustments. See Kallstrom, *Health Care Cost Control by Third Party Payors: Fee Schedules and the Sherman Act*, 1978 Duke L.J. 645, 650. Respondents acknowledge that "in 1979 eighty-five to ninety-five percent of physicians in Maricopa County billed at or above the maximum reimbursement levels adopted by Maricopa Foundation in 1977" (Br. in Opp. 8 n.24; see Pet. App. 3). Respond-

[34] For the reasons summarized above, moreover, neither doctors nor insured patients have a direct financial incentive to reduce insurers' costs by limiting use of medical services, and doctors have no incentive to pass on any savings from increased efficiency. See generally, Council on Wage and Price Stability, Executive Office of the President, *The Complex Puzzle of Rising Health Care Costs: Can the Private Sector Fit It Together* 11-13, 83-88 (1976).

ents also acknowledge that they make upward revisions in their maximum fees when those fees fall below prevailing or customary fee levels (Br. in Opp. 4; see Petitioner's Reply Memorandum, Appendices A-C).

b. Fortunately, our economy need not look to horizontal maximum price fixing by sellers of medical services to contain health service costs. In the absence of horizontal price agreements, significant price competition could develop in the market for health care services even when payments for such services are made through insurance plans. Insurers have a direct financial incentive to negotiate for fee levels that would minimize costs for services rendered to their subscribers while allowing them to attract a sufficient number of qualified doctors to make their insurance plans marketable. Similarly, in the absence of horizontal price agreements, doctors who wished to sell their services to insurers, that is, who needed insured patients to maintain a profitable volume of business, would have an economic incentive to price their services so that insurers would do business with them.

Insurers who successfully negotiated lower maximum prices for medical services would be in a position to charge lower premiums for similar benefits.[35] And competition among insurers could be expected to force them to pass at least some of their savings on to subscribers. Thus, the benefits of prohibiting maximum price fixing by doctors would accrue to the general public even though many insured patients do not pay directly for medical services.[36]

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[35] Rather than offering the same benefits, of course, some insurers might offer a more limited choice of doctors or covered services at a lower cost. The development of such competitive options would benefit consumers. See Goldberg & Greenberg, *The Effect of Physician-Controlled Health Insurance*, 2 J. Health Politics, Policy and Law 48, 68-69 (1977).

[36] See Havighurst, *Health Insurers and Health-Care Costs*, 5 Health Commun. Informatics 319 (1979); Havighurst, *Controlling Health Care Costs*, 1 J. Health Politics, Policy and Law 471, 485-487 (1977); Kallstrom, *Health Care Cost Control by Third Party Payors: Fee Schedules and the Sherman Act*, *supra*, 1978 Duke L.J. at 647-649, 678-681.

In contrast, when insurers are faced with a price schedule fixed by a combination of doctors embracing most of the practitioners in a given geographic area, the insurers' efforts to restrain costs by fostering price competition at the provider level are impeded.[37] Insurers wishing to do business with such a powerful combination must agree to pay any price up to the maximum prescribed by the doctors themselves. Insurers and consumers are then deprived of the cost benefits that would result from competitive decisionmaking by doctors. See *Kiefer-Stewart Co.* v. *Joseph E. Seagram & Sons, Inc.*, 340 U.S. 211, 213 (1951); L. Sullivan, *Antitrust*, *supra*, § 78 at 210-212. In its understandable desire to contain health care costs, the court of appeals unfortunately lost sight of the fact that maximum price agreements of the type here involved frustrate the *competitive* system of "cost containment" mandated by Congress under the Sherman Act.

CONCLUSION

The decision of the court of appeals should be reversed.

Respectfully submitted.

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[37] As indicated on page 9, n.11, *supra*, both defendant foundations embrace more than 70% of the physicians in their respective areas. As a result, there is an aggregation of significant market power, under any measure, in the hands of the sellers of medical services.

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No. 80-419

IN THE

Supreme Court of the United States

October Term, 1980

STATE OF ARIZONA,

Petitioner,

against

MARICOPA COUNTY MEDICAL SOCIETY,
MARICOPA FOUNDATION FOR MEDICAL CARE, and
PIMA FOUNDATION FOR MEDICAL CARE,

Respondents.

ON WRIT OF CERTIORARI TO THE UNITED STATES
COURT OF APPEALS FOR THE NINTH CIRCUIT

BRIEF *AMICI CURIAE* OF THE AMERICAN ASSOCIATION OF RETIRED PERSONS AND THE NATIONAL RETIRED TEACHERS ASSOCIATION IN SUPPORT OF THE PETITIONER

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ON WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE NINTH CIRCUIT

BRIEF *AMICI CURIAE* OF THE AMERICAN ASSOCIATION OF RETIRED PERSONS AND THE NATIONAL RETIRED TEACHERS ASSOCIATION IN SUPPORT OF THE PETITIONER

QUESTION PRESENTED

Whether an agreement among competing physicians establishing fee schedules for their services is illegal *per se* under Section 1 of the Sherman Act.

STATEMENT OF INTEREST OF *AMICI CURIAE*

The American Association of Retired Persons (AARP) and the National Retired Teachers Association (NRTA),

of 1909 K Street, N.W., Washington, D.C. 20049, are affiliated and jointly administered not-for-profit membership corporations of more than 12,500,000 persons over the age of 55. This figure represents approximately one out of four people over the age of 55 nationwide, the largest organized group of older Americans in the country. Among the purposes of AARP and NRTA are: to enhance the quality of life for older persons; to promote independence, dignity and purpose for older persons; to lead in determining the role and place of older persons in society; and to sponsor research on physical, psychological, social, economic and other aspects of aging.

As retired persons, members of AARP and NRTA generally live on relatively fixed incomes and, because of their advanced age, many also depend on regular or frequent health care for their continued well being. Because of the need to limit the already high, and rapidly increasing, cost of health care, including physicians' fees, this case is especially critical to the health and welfare of AARP and NRTA members and of all older Americans.[1]

1. The elderly spend a far greater amount *per capita* on health care each year than younger persons. In 1979, the average annual health care expenditure for persons over 65 was $2,257 or 3½ times the average amount for citizens under 65. While older Americans comprise only 11.2% of the population, they spend 29% of the total nationwide expenditure for personal health care. In 1979, $40.6 billion, or 19% of total national health care expenditure went directly for doctors' bills, approximately $180 per person. Persons over the age 65 visit a physician an average of 6.3 times per year compared with the average of 4.8 times for individuals generally. The elderly require physicians' services not only more frequently, but for more complicated and therefore more expensive treatment than the average individual. Compounding the rate of increase in doctors' fees is the increase in out-of-pocket costs to older Americans for services rendered by these doctors. Only 46% of physicians accept Part B medicare reimbursement as payment in full for their services. Older Americans must assume substantial costs in the form of Medicare deductibles, coinsurance and fees in excess of the Medicare "reasonable-charge" reimbursements for doctors' services. For Americans over the age of 65, a full 41.8% of physicians' services are paid for privately. Gibson, *National Health Expenditures 1979*, 2 HEALTH CARE FINANCING REVIEW 1 (Summer 1980); Fisher, *Differences By Age Groups in Health Care Spending*, 1 HEALTH CARE FINANCING REVIEW 4 (Spring 1980).

The overriding interest of AARP and NRTA in the health care field is to foster and promote efficient delivery to the elderly of the best possible services at the least possible cost, thus making them readily available even for persons living within fixed and limited incomes. AARP and NRTA have advanced and supported introduction of strong cost containment measures which foster competition in the health care industry, because *amici* steadfastly maintain that elimination of all anti-competitive barriers is essential if the ultimate goal is to be achieved. To this end, *amici* have consistently argued before federal and state legislatures and administrative agencies that the health and medical professions should not be exempt from the antitrust laws and that all existing state or federal antitrust exemptions in the health care field should be abolished.[2]

Instead of reducing the scope of such exemptions, the decision of the Ninth Circuit herein has created what amounts to a *new* exemption for physicians from Section 1 of the Sherman Act. It seeks to justify creation of this new exemption for physicians simply because there already exist anti-competitive characteristics in the health care industry! This is paradoxical at best and dangerous at worst. The absence from the health care field of "ideal

2. The Health Policy chapter of the AARP-NRTA 1981 Federal and State Legislative Program was introduced into the Congressional Record by Senator David H. Pryor (D-Ar.), on April 7, 1981, 127 CONG. REC. S3565; in addition *amici* have testified and submitted statements to the House Budget Committee on March 13, 1981 and to the Senate Finance Committee on March 26, 1981 in respect of the administration's proposed budget reductions in health and social services; to the FTC on April 30, 1980 in respect of "Medical Participation in Control of Certain Open-Panel Medical Prepayment Plans"; to the Senate Finance Committee on April 11, 1980 in respect of "Health Care and the Elderly in the Present Economic Climate"; to the Health Subcommittee of the Senate Finance Committee on March 18, 1980 in respect of The Health Incentive Reform Act of 1980 (S.1968); and to the Health Subcommittee of the House Interstate and Foreign Commerce Committee on February 14, 1978 in respect of the Health Planning and Resources Development Amendments of 1978 (H.R. 10460).

competitive conditions"[3] bears no logical relation to the Ninth Circuit's conclusion that physicians' price arrangements in Maricopa and Pima counties are not *per se* contracts or combinations in "restraint of trade."[4]

Fixed and uniform fee-for-service schedules, such as those adopted by the physicians in Maricopa and Pima Counties, are in diametric opposition to the strong cost containment measures, such as negotiated fee schedules and prospective reimbursement, that *amici* have advanced in their endeavor to promote competition in the health care field. These measures involve pre-encounter budgeting for patient care and hold the physician accountable for expenditures in excess of the budget, thereby giving health care consumers, more often than not older people, some control over the cost of treatment.

The consequence of the Ninth Circuit's decision will be to enable physician groups, moreso than ever, to control with impunity third-party payor plans.[5] The result of such judicially condoned unfair and anti-competitive trade practices can only be inevitably to reduce and eliminate competition and to aid physicians in achieving target level incomes at the expense of consumers of health care services who are, disproportionately, older Americans.

ARGUMENT

Amici respectfully join in the legal argument advanced by the Petitioner and by the *amici curiae* in support of the Petitioner, including the United States. We respectfully highlight below several points of direct concern to AARP and NRTA.

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3. *See* Appendix A to the Petition, p 6.
4. *See* § 1 of the Sherman Act, 15 U.S.C. § 1.
5. Horizontal price fixing such as that engaged in by the Maricopa and Pima County Foundations translates directly into increased Medicare program costs under the "reasonable charge" reimbursement standard set by Congress. *See* 42 U.S.C. §§1395u, 1395x(v)(l)(A).

I.

THE NINTH CIRCUIT'S CREATION OF A SPECIAL ANTITRUST EXEMPTION FOR HORIZONTAL PRICE FIXING AMONG PHYSICIANS THREATENS TO DESTROY ANY CHANCE FOR HEALTH CARE COST CONTAINMENT.

The Ninth Circuit upheld an exemption for physicians from established antitrust standards of enforcement, because it was "confronted with an industry widely deviant from a reasonably free competitive model."[6]

In other words, says the Ninth Circuit, because no competition exists now, it is acceptable to permit admittedly anti-competitive practices to continue unchecked. But it is these very anti-competitive practices which Congress sought to stamp out via the Sherman Act. The fact that the health care field may be markedly anti-competitive cannot be used as a crutch to condone and encourage the carving out of an undesirable exemption from the Sherman Act. The Ninth Circuit opinion threatens to eliminate in one fell swoop all recent Congressional action designed to foster competition, which *amici* have vigorously supported.[7]

Congress, recognizing the anti-competitive features of the health care field, has denominated the strengthening of competition as a national health priority[8] and has established incentives specifically aimed at fostering competition in the health care marketplace. *Amici* have worked hard to promote implementation of these and other responses to the anti-competitive nature of the health care field.

Judge Sneed's opinion below endows the medical profession with a protected status and creates a dangerous precedent in defense of price fixing by ruling that it is the *reasonableness* of the fixed prices that is determinative, as opposed to the *act* of fixing those prices by contract or

6. *See* Appendix A to the Petition, p. 6.
7. *See, e.g.*, 42 U.S.C. § 300k-2(a)(17); *See also* Footnote 2, *supra*.
8. 42 U.S.C. § 300k-2(a)(17).

agreement, even though that act might otherwise be in direct contravention of § 1 of the Sherman Act. This new "rule of reason" would seem to require that with each change in price, the burden falls on the consuming public to institute suit and seek a court determination on the "reasonableness" of the newly established price list. The opinion ignores the fact recognized by Congress and this Court that today's so-called fixed but "reasonable" price will undoubtedly be tomorrow's fixed and unreasonable price.[9]

Furthermore, where it is possible to create a competitive environment, as clearly seems feasible in the health care field, it should not be for doctors or courts to substitute their judgment as to the reasonableness of prices for the normal forces of the market. It is, therefore, not in the public interest that a judicial exemption for the medical profession be permitted to stand or that doctors be permitted to fix prices.

II.

OLDER AMERICANS ARE ENTITLED TO PURCHASE AND NEGOTIATE FOR DOCTORS' SERVICES IN AN OPEN, COMPETITIVE MARKETPLACE.

The Sherman Act is a clear enunciation of the consumer's right to negotiate for all goods and services, including physicians' services, at arms-length, in an open, competitive marketplace. This right has been reaffirmed in recent legislation.[10]

The Ninth Circuit's opinion, condoning physicians' price fixing because the prices may be "reasonable", bypasses the relevant statutory inquiry, i.e. has there been price fixing?[11] If there has been price fixing, by definition, competition has

9. *See* Footnote 8 *supra: See also National Society of Professional Engineers* v. *United States,* 435 U.S. 679, 689 (1978); *United States* v. *Socony-Vacuum Oil Co.,* 310 U.S. 150, 212-224 (1940); *United States* v. *Trenton Potteries Co.,* 273 U.S. 392,397 (1927); *United States* v. *Trans-Missouri Freight Ass'n,* 166 U.S. 290, 340-341 (1897).

10. *See, e.g.* 42 U.S.C. § 300k-2(a)(17).

11. *See* Appendix A to the Petition, pp. 6-7, 31.

indeed been restrained, and the consumers of health care, a disproportionate number of whom are older Americans, have thereby been deprived of the competitive market conditions which are desireable to bring them the best health care at the lowest cost.

If the Ninth Circuit's decision is affirmed, it will constitute judicial sanction of the absence of competition in delivery of health care services and will act as a brake on the efforts of *amici* and others to expand such competition in order to improve the availability and quality of health care for the elderly.

CONCLUSION

Price fixing arrangements among physicians, which can result only in higher health care costs for vulnerable older Americans, and indeed for all consumers of medical services, should not be afforded judicial sanction.

WHEREFORE, the decision of the U.S. Court of Appeals for the Ninth Circuit should be reversed.

Respectfully submitted,

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Dated: June 5, 1981
New York, New York

EXHIBIT A

CONSENT OF PETITIONERS TO FILING OF BRIEF
AMICI CURIAE

LETTERHEAD OF ARIZONA ATTORNEY GENERAL

June 3, 1981

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& Raives
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Re: *State of Arizona* v. *Maricopa County Medical Society, et al.*

Dear Mr. Greenwald:

The State of Arizona hereby consents to your filing an *amicus* brief on behalf of your clients, the American Association of Retired Persons and the National Retired Teachers Association, in the above referenced case.

Very truly yours,

/s/ CHARLES L. EGER
Charles L. Eger
Assistant Attorney General
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EXHIBIT B

CONSENT OF RESPONDENTS TO FILING OF BRIEF *AMICI CURIAE*

LETTERHEAD OF BROWN & BAIN

May 15, 1981

State of Arizona v.
Maricopa County Medical Society

Dear Mr. Greenwald:

Confirming our telephone conversion of May 14, I am authorized on behalf of respondents to state that they do not object to your filing an *amicus* brief in the above-captioned matter on behalf of your clients, the American Association of Retired Persons and the National Retired Teachers Association.

Very truly yours,

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